Summer 1997

A Comparison of Factors Associated With Referrals, Service Placements and Length of Service for African-American and Caucasian Youth With Serious Emotional and Behavioral Disturbances Served Through the Comprehensive Services Act in Virginia

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A COMPARISON OF FACTORS ASSOCIATED WITH REFERRALS, SERVICE PLACEMENTS AND LENGTH OF SERVICE FOR AFRICAN-AMERICAN AND CAUCASIAN YOUTH WITH SERIOUS EMOTIONAL AND BEHAVIORAL DISTURBANCES SERVED THROUGH THE COMPREHENSIVE SERVICES ACT IN VIRGINIA

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Dissertation submitted to the Faculty of Old Dominion University in partial fulfillment of the requirement for the degree of

Doctor of Philosophy

Urban Services/Health Services

Old Dominion University

August 1997

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ABSTRACT

A COMPARISON OF FACTORS ASSOCIATED WITH REFERRALS, SERVICE PLACEMENTS AND LENGTH OF SERVICE FOR AFRICAN-AMERICAN AND CAUCASIAN YOUTH WITH SERIOUS EMOTIONAL AND BEHAVIORAL DISTURBANCES SERVED THROUGH THE COMPREHENSIVE SERVICES ACT IN VIRGINIA

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Despite the efficacy of community-based treatment, many emotionally and behaviorally disturbed youth still receive restrictive service placements. This is quite problematic for minority youth since studies have reported they are more at risk of out-of-home placements. The purpose of this study was to examine differences in referrals, out-of-home placements, residential placements and length of service for African-American and Caucasian youth. This historical cohort study was a secondary analysis of data from the Comprehensive Services Act in Virginia. The sample consisted of 2,883 youth ages 10 - 19. Multiple logistic regression was employed for data with dichotomous outcomes in order to adjust for factors such as age, gender and presenting problem. Multiple linear regression was employed for interval outcome data in order to adjust for age, gender and presenting problems.

Ethnic differences were noted for type of referral, out-of-home placement, residential placements and length of service. African-Americans were more likely to have formal and social agency referrals to CSA than Caucasian youth. The effect of ethnicity on school referrals was found to depend on whether the youth

had abuse, cognitive an emotional problems. Among youth without these problems, African-Americans were less likely to have school referrals. Among youth with these problems, African-Americans were over 2 times more likely to have referrals from schools. Furthermore, African-Americans were 1.32 times more likely to have out-of-home placements prior to CSA enrollment than Caucasians. The effect of ethnicity on residential placements was found to depend on whether the youth was delinquent. Among youth who were delinquent, African-Americans were .755 times less likely to have residential placements while receiving services through CSA. African-Americans were also found to have a significantly shorter (295.7) length of service in CSA than Caucasians (353.6).

This study indicates some of the factors associated with referrals, out-of-home placements, residential placements and length of service for youth with serious emotional and behavioral problems in the child mental health system. Ethnicity was found to be a significant factor associated with type of referrals, placements and length of service. Policy makers and service providers should be apprised of the fact that African-American youth may have different paths to treatment and these differences may affect the type of placement, and length of service for these youth. More information is needed that will document how these factors may affect treatment outcomes for African-American youth.

Dedication

This work is dedicated to my loving mother and husband for their encouragement, support and inspiration.

Acknowledgements

I thank God for restoring my health and allowing me to finish this research. I am indebted to many people for their help in completing this research. I would like to express my sincere appreciation to my dissertation committee for their support and invaluable assistance. I am especially grateful to my committee chair and mentor, Dr. Richardean Benjamin-Coleman for her patience, support, and leadership. She has been essential to my development throughout the program. I feel very fortunate that I was able to work as her assistant. That experience led to presentation opportunities which eventually led to this research.

I am also grateful to Dr. Clare Houseman for her accessibility and support which has been pivotal throughout the pursuit of my doctoral degree and completion of the research. I would also like to thank Dr. Jeffrey Levin for serving on my committee and providing me with encouragement and valuable insight regarding the research methodology.

I am indebted to the Department of Mental Health/Mental Retardation/Substance Abuse Services for allowing me to utilize data from the Comprehensive Services Act. I am particularly grateful to Dr. Al Watts for assisting me in securing the data and providing me with technical assistance. I would also like to thank Gray Shoot for downloading the data and being available for technical questions.

I would like to especially thank Patrick Hannon for his patience and willingness to provide me with consultation for the statistical analysis. I also appreciate Dr. Gretchen LeFever for her encouragement and sharing her expertise in clinical psychology. I am extremely thankful to Dr. John Pestian for providing me with the necessary flexibility in my work schedule to focus on my dissertation. I would also like to thank Dr. Ardythe Morrow and Debra Chase for their support and assistance. I am grateful to the individuals who read portions of this document at various stages of its development: Sybil Satterfield, De Witt Webster and my Aunt Joan Hamilton. Also, I would like to thank Cynthia Murray for her editing assistance. In addition, I would like to express my appreciation for the on-going support and kindness of Eloise Foster, Angie Hairston, Connie Davis, and Emily Hauser. I would also like to thank my mother for her readiness to offer emotional and financial support throughout this process. I appreciate the prayers and encouragement I received from a host of family members, friends, and colleagues. Last, but not least, I would like to express my sincere gratitude to my husband Earle for his patience, unwavering support, and belief in my abilities.

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Chapter I

INTRODUCTION

Background

It has been almost 20 years since the President's Commission on Mental Health (1978) established national priorities for mental health research regarding minorities. Although progress has been made regarding the general awareness of the mental health needs of youth, knowledge of the mental health needs and the use of mental health services by minority youth is still lacking (Burns & Friedman, 1990; Hoberman, 1992). This is quite problematic given that many of today's youth are members of minority groups and ethnicity has been posited to have multiple influences on their mental health (Hoberman, 1992). Little data is available which describes their behavioral and emotional problems, the extent to which services are used, and the degree to which service needs are not met for minority youth (Hoberman, 1992). Differential mental health placements and use of mental health services are continuing problems for minority youth (Stehno, 1982; Issacs-Shockley, Cross, Barzon, Dennis & Benjamin, 1996). Differences in placement are evident in minorities' over-representation in inpatient treatment and residential facilities. This chapter provides background data regarding mental health services for youth. Specifically, the chapter covers (1) the prevalence of mental health disorders, (2) types of psychiatric disorders among children and adolescents, (3) the children's mental health system, (4) national studies of children and adolescents' use of mental health services, (5) the urban significance of the problem, (6) statement of the problem, and (7) purpose of the research.

Prevalence of Mental Health Disorders

Children and adolescents are confronted daily with circumstances which threaten their propensity to develop into well-adjusted adults. The academic community, policy makers, the media and parents agree childhood is no longer a stress-free period, but more often a period of distress (Knitzer, 1993). Changing cultural values, homelessness, poverty and violence in the United States have created a new vulnerability in children for emotional problems (Duchnowski & Kutash, 1993).

The question of precisely "how many children have mental disorders?" has not been definitively answered to date (National Advisory Mental Health Council, 1990). Study reports suggest a prevalence range of 17 to 22% (11 million to 14 million children and adolescents) with diagnosable mental disorders. Epidemiological studies suggest one-fifth of all youth have at least one diagnosis that meets DSM-III-R criteria (Realmuto, Bernstein, Maglothin & Pandey, 1992). The most conservative estimate of children who suffer with mental illnesses is 12% of the 63 million youth in this country (National Advisory Mental Health Council, 1990). These figures represent between 7.5 and 9.5 million children who suffer from conditions such as emotional disorders, behavioral disorders, psychological delays and learning disorders (U.S. Department of Health and Human Services, 1990). Of these 7.5 million youth, almost half are assumed to be severely handicapped by their mental disorder. The prevelance of serious emotional and behavioral disorders is reported to range from 9 to 19% (Costello, Edelbrock, Costello, Dulcany, Burns & Brent, 1988; Kashani, Ezpeleta, Dandoy,

Doi & Reid, 1991; Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen, & Kendler, 1994). In instances where the mental illness is less severe, children and adolescents may still have serious difficulties in coping with the requirements of school, family, and community life. Unfortunately, reports estimate that less than 2% of youth in the United States use any type of mental health service (Burns, 1991).

According to the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (1994), the prevalence estimate of mental health needs for children 0 to 17 years old is 11.8% (177,000 children). Of that number, 5% (n=8,850) youth are estimated to have serious emotional disturbances. The Department's report of unduplicated use of community mental health services revealed a total of 114,243 children received services, 17,407 with mental health needs and a subset of 4,027 children with serious emotional disturbances.

Based on the ratio of those in need and those who were served in the community mental health system, 65% of children with mental health needs were served in the public mental health system and 46% of children with serious emotional disturbances (SED) were served. Although this represents an unmet need of 35% for all children and 54% for children with emotional disturbances, these figures do not take into account children served in the private sector.

Types of Psychiatric Disorders among Children and Adolescents

Available studies regarding the psychiatric disorders among youth have consistently demonstrated that the rates of psychiatric disorders among youth appear quite similar to those found among adults. Anxiety disorders, conduct

disorders, and depression are the most common mental health problems identified among youth. Although substance abuse rates have not typically been reported in epidemiological studies, the results of annual surveys of substance abuse indicate alcohol and drug usage increases dramatically during the middle adolescent years and peaks for youth between 18 and 21 years. Generally, rates of internalizing disorders (i.e., somatic complaints, anxiety/depression) exceed externalizing disorders (i.e., delinquency behavior, aggressive behavior). Co-morbidity rates of psychiatric conditions are quite high for youth with mental health conditions, ranging from 25% to 75% (Hoberman, 1992). In addition, recent research indicates high rates of chronicity or recurrence for a number of common psychiatric disorders common during adolescence including depressive and conduct disorders. Overall, there is remarkable convergence in the results of all existing epidemiological studies suggesting at least one out of five young persons has experienced a recent psychiatric disorder and many of these individuals experience multiple and chronic difficulties.

Children's Mental Health System

Researchers have characterized the child mental health system as fragmented, over-reliant on restrictive care and under-utilized by populations who need these services (Knitzer, 1982). Many reports and commissions have echoed these findings for children with emotional disturbances. Problems in the child mental health arena transcended boundaries of ethnicity, socioeconomic status, and geography. All children, rich, poor, rural, urban and all ethnic groups were in need of mental health services (Joint Commission on the Mental Health of

Children, 1969). This was also true in 1978 when the President's Commission on Mental Health indicted the nation and stated that none of the "eloquent recommendations" throughout previous years had been implemented to any significant degree (President's Commission on Mental Health, 1978). However, since the mid 1980s significant changes and progress have been made in the delivery of child mental health services with the development and implementation of coordinated systems of care (Stroul & Friedman, 1986; Stroul, 1996).

Knitzer's (1982) landmark study raised the nation's consciousness regarding the dismal state of children's mental health services. The study revealed the lack of federal and state involvement in youth's mental health services and accentuated the public's failure to develop appropriate systems of care for children with emotional and behavioral disturbances. Knitzer's (1982) findings indicated three million youth had serious emotional disturbances and two-thirds of these youth were not receiving necessary services. In addition, she found less than half of the states with responsibility for child and adolescent mental health had separate standards for child and adolescent mental health services and there was little intra-agency collaboration. Since the 1980s there have been significant changes in the manner of delivery of services to youth with serious emotional disorders. These changes led to the development of a system-of-care model for youth with serious emotional disturbances. This model was pivotal in the successful shifts in the child mental health system. The system of care has improved service delivery by increasing family involvement and cultural sensitivity. As proposed by Stroul and Friedman (1986) a system of care is defined as:

> A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families (Stroul & Friedman, 1986, p. xx)

The underlying philosophy of the system of care is that youth with emotional disturbances should be served in the least restrictive setting appropriate for the needs of the child and family (Kutash, 1996). Components within a system of care include: mental health services, social services, educational services, health services, substance abuse services, vocational services, recreational services, and operational services (case management, family support services) (Stroul & Friedman, 1986). Mental health services include both residential and nonresidential services. Nonresidential services within a system of care include prevention, early identification, assessment, outpatient treatment, home-based services, day treatment and emergency services. Residential services include therapeutic foster care, therapeutic group care, therapeutic camp services, independent living services, residential treatment services, crisis residential services and inpatient hospitalization (Stroul & Friedman, 1986).

Increases in federal leadership have greatly helped improve the child mental health care system. Leadership at the federal level has been largely provided through the National Institute of Mental Health with the development of the Child and Adolescent Services System Program (CASSP) in 1984. The goal of this program was to assist states and communities in developing systems of care for youth with serious emotional disturbances (SED). The program furnished

limited resources to states through a competitive grant process (Duchnowski & Friedman, 1990). Subsequently, many states embarked on various types of reforms in the delivery of children's mental health services. Currently all 50 states are involved with CASSP. In addition, every state mental health agency has at least one staff member devoted entirely to children's mental health (Stroul, 1996).

Often the most frequent and compelling reason that states reformed their fragmented child mental health service system was the escalating cost. The fact that emotionally and behaviorally disturbed children typically received services from several agencies often led to fragmented, duplicative and very costly care. Similar to other states, Virginia adapted Stroul and Friedman's System of Care Model to guide the restructuring and delivery of mental health services to youth with serious emotional and behavioral disturbances. Passage of the Comprehensive Services Act (CSA) in 1992 was the apex of several years of effort towards a statewide intragency system of care for troubled and at-risk youth and families (Macbeth, 1996). The CSA was passed in order to control escalating costs of restrictive residential services for children and to facilitate a more coordinated funding stream and interagency coordination in Virginia.

In 1990, the Secretaries of Health and Human Resources, Public Safety, and Education in Virginia formed a cross-secretarial interagency council to recommend changes to the service delivery system for severely emotionally and/or behaviorally disturbed children in Virginia. Much of the impetus for the council was a study of children's residential services conducted by the Department of Planning and Budget (1990). The study reported state and local expenditures for

residential care across four child-serving agencies would continue to increase significantly unless the Commonwealth instituted major policy and programmatic changes to the system of care. The Department of Planning and Budget recommended expanding community-based nonresidential services, improving interagency collaboration and services delivery, and adapting the state's funding policies and management systems. After several reports and recommendations, the Comprehensive Services Act was drafted and passed in 1992, which dramatically changed the administrative and funding systems of agencies which provided services to at-risk and troubled youth and their families.

The purpose and intent of the act is as follows:

> It is the intention of this law to create a collaborative system of services and funding that is child-centered, family-focused and community-based when addressing the strengths and needs of troubled and at-risk youths and their families in the Commonwealth (Virginia Acts of the Assembly, Chapter 880, Section 2.5-745).

The law is to be interpreted and construed as to effectuate the following purposes:

1. Insure that services and funding are consistent with the Commonwealth's policies of preserving families and providing appropriate services in the least restrictive environment, while protecting the welfare of children and maintaining the safety of the public;
2. Identify and intervene early with young children and their families who are at risk of developing emotional or behavioral problems, or both, due to environmental, physical or psychological stress;

3. Design and provide services that are responsive to the unique and diverse strengths and needs of troubled youths and families;
4. Increase interagency collaboration and family involvement in service delivery and management;
5. Encourage a public and private partnership in the delivery of services to troubled and at-risk youths and their families; and
6. Provide communities flexibility in the use of funds and authorize communities to make decisions and be accountable for providing services in concert with these purposes (Virginia Acts of Assembly, Chapter 880, Section 2.1-745.

Youth targeted for services through CSA have serious emotional or behavioral problems which:

> have persisted over a significant period of time or, although only in evidence for a shorter period of time or are of such a critical nature that intervention is warranted, are significantly disabling and are present in several community settings, and require services or resources that are unavailable or inaccessible, or that require coordinated intervention by at least two agencies (Comprehensive Services Act for At-Risk Youth and Families, 10092, Section 2.1-7558).

Priority is given to youth with serious emotional and behavioral problems who are in residential group care or who are at risk of placement, and who require coordinated services (Macbeth, 1996). A second part of the act targets young children at risk of later serious emotional or behavioral problems and their

families.

National Studies of Children's and Adolescents' Use of Mental Health Services

Studies of child and adolescent mental health use have typically involved a comparison of prevalence data and the actual or estimated use of needed mental health services. The need for children's mental health services has been assessed using symptom checklists and diagnostic criteria. Study samples have included reports from schools and private physicians and an array of available treatment settings. Sparse information exists on a national level of the service use and unmet needs of children and adolescents (Burns, 1991). Due to the fact that service use between the general health system and other sectors is often excluded from national reports, and that the availability of services varies according to regions, national studies may not represent the total capacity of service use. These are significant issues because children receive treatment in a variety of settings. Nevertheless, national studies are useful in estimating the gap between the need for and the use of mental health services.

Burns (1991) conducted one of the most comprehensive national studies of child and adolescent mental health service use. The study examined the utilization of services by youth aged 10 to 18 and included cross-sectional data for 1986 and longitudinal data from 1975 to 1986. The Survey and Reports Branch, Division of Biometry and Applied Sciences, National Institute of Mental Health (NIMH) was the source of data for this study. A sample of facilities was drawn to include the following four levels of care: outpatient, partial hospitalization, and residential treatment and inpatient facilities. Significant study findings revealed

that although the majority (69%) of youth received care in outpatient settings, three-fourths of the mental health expenditures were for residential and institutional services. The overall services use rate for all levels of care was 1.9% for the 10 to 18 year-old populations. Subsequently, Burns (1991) concluded that less than 2% of youth were expected to receive mental health services.

Mental health services for children encompass a wide spectrum of traditional and non-traditional systems of mental health care. Traditional systems include mental health facilities such as psychiatric hospitals, community mental health centers and residential treatment facilities. Non-traditional systems include: education, welfare, juvenile justice and general medical systems. Studies have shown that mental health professionals see few of the children who have psychiatric problems and the general, medical and judicial systems are heavily utilized (Offord, Boyle, Szatmari, Brae-Gant, Links, Cadman, Byles, Crawford, Blum, Byrne, Thomas, & Woodward, 1987). Knitzer (1989) found that schools and child welfare agencies play a significant role in the provision of children's mental health services.

Mental health care treatment settings for children range along a continuum with broad distinctions between inpatient and outpatient care. Inpatient hospitalization, the most restrictive setting, is on one end of the continuum, and outpatient centers and community-based services are on the other (Tuma, 1989). Although there is consensus in the child mental health arena that children should be served in the least restrictive setting (Behar, 1984; Knitzer, 1982); Padgett, Patrick, Burns, & Schlesinger, 1993), utilization rates seem to indicate an

over-reliance on restrictive settings. The number of youth who received services in residential settings is unreliable, given the various methods used to place children in residential settings, but it appears to be rising (Yelton, 1993; Kutash, 1996).

Most researchers anticipated a decrease in the use of inpatient mental health services for children and adolescents in the 1970s with the deinstitutionalization movement, but utilization patterns did not decline as expected. Tuma (1989) reports there were some decreases in the use of restrictive settings for children. However, trends of service use during the 1970s and 1980s only indicated minor reductions in the use of state and county hospitals. These declines were countered with increases in admissions to private psychiatric hospitals (Padgett et al., 1993). A psychiatric epidemiological study of children by Vikan (1985) revealed the frequency of admissions to private psychiatric hospitals increased by almost 200% from 1970 to 1980. Burns (1991) reported an increase of 33% in overall admission rates to inpatient facilities from 1980 to 1986. Burns also cited that only an estimated 1% of children 10 to 18 years old used outpatient mental health services in 1986. Kiesler and Simpkins (1991) found an 87% increase of episodes of residential and inpatient treatment for children. A study by Realmuto et al. (1992) reported that about 3.2% of children under 18 had visits to outpatient centers.

In a Virginia study of residential placements in the child mental health system, 78% of the total expenditures for residential care was for restrictive or out-of-community residential programs (Virginia Department of Planning and

Budget, 1990). In addition, older children (10 to 19 years old) were found to be over-represented in residential facilities, comprising 95.7% of all children in residential care. These studies suggest that regardless of the higher costs of inpatient and residential care and the consensus by professionals as to the efficacy of outpatient treatment, restrictive settings are over-utilized for children, particularly older adolescents (Bickman, Heflinger & Behar, 1992; Virginia Department of Planning and Budgeting, 1990).

Urban Significance

Crime, poverty, homelessness and the number of single-parent families are factors which place urban children and adolescents at great risk for developing mental health disorders (Rutter, 1981). The incidence rates of virtually all types of psychological problems are usually higher in urban areas. Studies which have compared the disorders of rural and urban children have found higher emotional and behavioral problems in the cities (Rutter, Cox, Tupling, Berger & Yule, 1975; Quinton, 1988; Hoberman, 1992). Although the need for services to deal with children's psychological problems is evident, many necessary children's mental health services remain unavailable. There continues to be a significant discrepancy between the number of children who are identified as in need of mental health services and those who receive treatment (Cohen & Hesslebart, 1993). This is particularly true for minority and urban adolescents. Use of residential care by urban children in Virginia appeared disproportionately greater than use by children in rural communities (Virginia Department of Planning and Budget, 1990). More information on all types of mental health service use is

critical for sound policy development and successful service delivery.

Statement of the Problem

Although there is consensus regarding the efficacy of community-based treatment for disturbed youth, many states still place children and youth with serious emotional disturbances (SED) in restrictive and residential facilities out of their home state (Hill, 1996). This is extremely problematic for minorities in that minority males and low income youth are at great risk for residential placement. In addition, studies have reported that African-American males are disproportionately identified as having (SED) (Knitzer, Steinberg & Fleisch, 1990; Marder & Cox, 1991). Similarly, children with emotional disturbances have a higher probability of coming from lower social economic status (SES) homes (Bernard & Clarizo, 1981; Frazier & DeBlassie, 1984; Marder & Cox, 1991). A study by the Virginia Department of Planning and Budget (1990) found males and minorities were over-represented in residential care. Seventy-four percent of adolescents in residential placements were male, although males (between the ages of 10 - 19) comprise only 51% of the total children in the state. Similarly, although minorities only accounted for 25% of Virginia's youth aged 10 to 19, 40% of children in residential care were of a minority race (Virginia Department of Planning and Budget, 1990). In fiscal year 1994 in Virginia, the majority of youth in CSA received residential placements. The costs of these residential services were 81% of total costs in CSA. There were 6,521 youth in residential placements averaging $12,989 per child. Fewer youth were in non-residential placements with costs averaging $6,051 per youth.

Overall, very little is known regarding how minority youth access or utilize mental health services (Hoberman, 1992). More information is available concerning African-Americans' patterns of use than other ethnic groups. Yet, available data concerning other ethnic groups make the African-Americans' utilization patterns seem more contradictory. For example, Mexican-Americans have been found to experience similar barriers to the use of mental health services as African-Americans. Nonetheless, Mexican-Americans are under-represented in community mental health clinics and utilize these services significantly less than African-Americans (Snowden & Cheung, 1990). Mexican-Americans' patterns of under-use of mental health services appear consistent with their reported reluctance to seek mental health care (Takeuchi, Bui, & Kim, 1993). On the other hand, African-Americans' reported reluctance to seek mental health care contradicts research of their over-representation in inpatient treatment. Therefore, although minority groups may demonstrate similar patterns of reluctance to seek help from mental health professionals, utilization patterns differ. This is particularly true for African-Americans. Perhaps factors other than those relating to African-Americans' decision to seek care influence their placement in mental health facilities. More research is needed to help understand this discrepancy (Cheung & Snowden, 1990).

Suggested explanations as to African-Americans' over-representation in inpatient facilities include socioeconomic status, a greater prevalence of mental health problems among minorities, and poverty status differences between minority youth and Caucasian youth. Little evidence exists to support the claim

that greater prevalence of severe mental illness is associated with minority status. In addition, researchers have found ethnic differences persist even when controlling for socioeconomic variables and patterns of out-of-home placements are dramatically higher for minority youth than for Caucasian youth (Stehno, 1982).

Takechui, Bui, & Kim (1993) propose that ethnic differences in patterns of mental health service use or mental health placements may be because African-Americans enter the mental health system under more coercive or formal conditions (i.e., the juvenile justice system) than other minority groups and Caucasians. The researchers propose that the manner in which mental health problems are identified translates into issues of access to mental health services as well as service placement. Subsequently, differences in mental health referrals have been linked to variations in treatment outcomes and length of stay in treatment. Despite implications of the relationship between referral source and treatment outcomes, few studies have centered on the referrals and pathways of minority adolescents to mental health care (Takeuchi et al., 1993). Even fewer studies have examined how an individual's referral to mental health services relate to the type of services used while in the mental health system.

The referral source may be an important factor in understanding different utilization and placement patterns of minority youth. Often, families and external agencies interpret the same behavior in youth very differently. The family may consider a certain behavior to be normal while schools and social agencies may label that same behavior as abnormal and requiring mental health intervention.

Rosenfield (1984) conceptualizes referral source by the degree of coercion or the formality of the societal response. The degree of coerciveness can range on a continuum from a referral by a friend to psychiatric confinement by the judicial system. Although sometimes necessary, coercive referrals may result in varying consequences for youth. For example, an agency referral may result in the youth being stigmatized with the family. On the other hand, a family referral may help the child (and family) overcome the stigma associated with seeking mental health care (Bui & Takeuchi, 1992; Takeuchi et al., 1993). This may be particularly significant for African-Americans since studies have shown them to associate a stigma with seeking mental health care (Hoberman, 1992). In addition, adolescents with referrals from external agencies are more likely to terminate prematurely from treatment and stay in treatment for shorter periods of time than those who enter treatment under more informal circumstances (Bui & Takeuchi, 1992). Furthermore, mental health professionals may evaluate a referral made by a family member differently than one made by a social agency. This difference may have possible implications for the mental health services used by youth.

Purpose

The primary purpose of this study is to examine the issue of over-representation of minority youth in restrictive residential and inpatient facilities (Snowden & Cheung, 1990; Fried, 1975; Milazzo-Sayre, Benson, Rosenstein, & Manderscheid, 1986; Virginia Department of Planning and Budget, 1990) by examining the patterns of residential placement and referral source for African-American and Caucasian youth in Virginia who receive services under the

Comprehensive Services Act (CSA).

The aims of this research are:

To provide further understanding of African-American and Caucasian youth's mental health utilization patterns by describing factors which affect their referral, placement and length of service in mental health services through Virginia's Comprehensive Services Act. The specific questions this study addresses are:

1. Are African-American youth more likely than Caucasian youth to have referrrals to CSA from formal sources?
2. Do African-American and Caucasian youth differ in the type of agency likely to refer them to CSA?
3. Are African-American youth more likely than Caucasian youth to have out-of-home placements prior to CSA enrollment?
4. Are African-American youth more likely to have residential placements while in CSA than Caucasian youth?
5. Do African-American and Caucasian youth differ in the length of service (LOS) in CSA?

Chapter II

THEORETICAL FRAMEWORK

In formulating a theoretical perspective to examine ethnic differences in mental health service use, societal reaction theory of mental illness, also referred to as labeling theory, provides a useful prototype. This theory presents a framework for examining different societal reactions to individuals. The theory purports that every society has explicit and implied rules or norms regarding appropriate behavior, perceptions, feelings and thoughts (Scheff, 1966; Scheff, 1984). Non-conformance to these norms (rules) is regarded as rule-breaking. Explicit norms include those items which society has characterized as violations such as crime or sexual harassment. These categorizations are generally derived from the rule that is broken and its associated type of behavior (e.g., drunkenness, theft). On the other hand, the violations for which there are no explicit labels are deemed residual rule-breaking. In general, society responds to rule-breaking in one of two ways: denial or labeling (Scheff, 1966). Denial means ignoring the rule-breaker's behavior while labeling is the process of identifying or tagging persons as deviants. A deviant is simply one who has been labeled as such. Labeling, then, appears as a subtype of societal reaction and focuses on the label society affixes to the deviant behavior (Towsend, 1980). Therefore, society is considered to be the audience which monitors, evaluates, and eventually labels or denies a rule-breaker's behavior. Central to this theory is the question as to why there are different societal reactions to rule-breaking for different groups and why some types of deviance last longer than others.

The labeling perspective centers on society's reaction to residual deviance. Accordingly, when an individual's behavior is disruptive or offensive and society cannot determine a "conventional label of deviance" (i.e., crime, etc.), society often develops a miscellaneous or residual category for that behavior (Scheff, 1966). An example of a societal reaction to residual deviance is the distinction made between "white collar" crimes and other "criminal" offenses. According to Scheff (1966) if "white collar" crimes were to be regarded as serious as "criminal" offenses and received more stringent punishments, persons in this category would be viewed as criminals, thus creating thousands of criminals by changing the response to the activity. According to labeling theorists, mental illness is a residual deviance category in modern society because its associated behavior is contrary to society's norms, yet it is not explicit rule-breaking.

Rather than center on the cause of residual deviance, labeling theorists have attempted to understand the variation in duration of residual deviance for different groups or individuals. The general hypothesis offered by the theory to explain this variation in duration is based on society's acceptance of the rule-breaking behavior. Accordingly, if residual rule-breaking is accepted by society, it will be short-lived because the deviant acts now become part of standard behavior. In turn, rule-breaking that is not accepted may lead to long-lived or stabilized deviance. An example of this would be homosexuality. The shift from the identification of homosexuality as a mental illness by psychiatrists and other key agents in society "promoted thousands of homosexuals out of their deviant status" (Scheff, 1984, p. 35).

The societal reaction perspective emphasizes the significance of factors "external to the individual as well as characteristics of the person himself" (Rushing & Esco, 1977, p. 135). The thrust of the theory is the reaction of society to mental illness rather than the social etiology of the mental illness (Lemert, 1974). As such, the theory avoids the question of why an individual has a mental illness, but stresses why there are different reactions from society for certain groups. A central proposition of the theory is that powerless and culturally marginal individuals, persons from subcultures in society (i.e. non-whites) have more severe societal reactions to their residual deviance (Horwitz, 1982; Scheff, 1966). For example, when examining mental illness hospitalization versus less severe forms of treatment, these individuals would be more likely to be hospitalized for their mental illness than those in more powerful or conventional groups (Rosenfield, 1984). In terms of the type of hospitalization or placement, powerless and culturally marginal individuals would also be more likely to experience a more coercive response of involuntary hospitalization as opposed to voluntary hospitalization (Rosenfield, 1984). Therefore, individuals of lower socioeconomic status and from minority cultures would be expected to have more severe reactions from society in response to their deviance than persons of higher economic status and from majority cultures or subcultures. This point could be illustrated using societal reaction to an alcoholic. For example the societal reaction to a white, male, well-dressed alcoholic from a high socio-economic status is viewed differently than an African-American, poorly dressed alcoholic with his/her bottle in a brown paper bag.

Application in Current Study

It is assumed that all youth in CSA have been labeled as having a serious emotional or behavioral disturbance; therefore, the question addressed in this study is not how some youth avoid being labeled and others do not. Rather the questions in this study are what audience (measured by the type of referral) evaluated the youth's behavior as in need of intervention, and how these referral sources or audiences differed among ethnic groups.

In obtaining mental health care, the referral source can be conceptualized as the audience which labels a youth's behavior as in need of social or therapeutic intervention (Takeuchi et al., 1993). Typically, a referral is made because the youth's behavioral or emotional problems threaten harm and disruption to some social unit (Mechanic, Angel, & Davies, 1991). The source of referral has been conceptualized by the degree or coercion or formality of the societal response (Rosenfield, 1984). According to Horwitz (1982), as a referral source's likelihood to rely on formal sanctions increases, it becomes more coercive. The degree of coerciveness or formality of a referral to mental health services can range on a continuum from a referral by a friend to confinement to a psychiatric hospital by the judicial system. However, the degree of formality of a referral alone does not dictate the appropriateness of one referral versus another. Although often necessary, coercive or formal referrals may have varying consequences for youth. The labeling perspective predicts persons of minority status will be less likely to initiate treatment and will be more likely to have a formal societal response to their residual deviance than non-minorities.

The societal reaction perspective suggests the cultural marginality of groups would make them at risk of more severe societal reactions. In terms of mental health treatment, this notion has been examined by centering on type of hospitalization and type of placement. Therefore, in terms of type of hospitalization or placement, powerless and culturally marginal individuals would be more likely to experience the more coercive societal response of mental health placements. These placements would include involuntary hospitalization as opposed to voluntary hospitalization and residential placements versus non-residential placement.

Based on the labeling perspective, the following hypotheses are offered to guide the study:

H1 African-American youth will be more likely to have formal referrals to CSA than Caucasian youth.

H2 African-American and Caucasian youth will have different societal reactions to their deviance as measured by difference in the probability of referrals from schools, health and social/legal agencies.

H3 African-American youth will be more likely to have previous out-of-home placements than Caucasians.

H4 African-American youth will have a significantly shorter length of service in CSA than Caucasian youth.

H5 Due to the propensity for formal societal reactions to their deviance, African-Americans will be more likely than Caucasians to have residential placements while receiving services through CSA than Caucasians.

Review of Literature

The review of literature will include discussions of relevant literature pertaining to (1) ethnicity and care-seeking, (2) ethnicity and need for mental health services, (3) ethnic-related differences in child and adolescent psychopathology, (4) the impact of socioeconomic differences, (5) clinical factors and societal reaction (6) limitations and problems related to diagnosing mental illness, (7) stigma associated with mental health service use (8) referrals to treatment and (9) availability of mental health services. The chapter concludes with a summary of the literature reviewed.

Ethnicity and Care-Seeking

Ethnicity has the potential to influence individuals' beliefs about mental health issues, the manner in which symptoms manifest, coping behavior, help-seeking patterns, utilization, and response to treatment (Gibbs & Huang, 1989; Hoberman, 1992). Members of all ethnic groups have been found to seek mental health care from formal mental health sources at different and typically lower rates than Caucasians (Shapiro, Skinner, Kramer, Steinwach & Regier, 1985). Literature on the care-seeking behavior of African-Americans has reported their under-use of mental health services (Sussman, Robins & Earls, 1987), over-use of inpatient settings (Broman, 1987; Sue, 1977) and reluctance to seek care. Studies of Asian and Pacific Islanders have consistently found these groups to seek care for mental health services in relatively low numbers (Snowden, 1988). Minority groups (African-Americans, Asian-Americans, Native-Americans, and Hispanic-Americans) are reported to be very unlikely to initiate treatment; however,

African-Americans are more likely than Caucasians to be admitted to state and county mental health hospitals. Some of the reasons for these different care-seeking patterns and service use patterns among ethnic groups may be attributed to differential tolerance for psychopathology particularly among African-Americans and Asian-Americans; the stigma associated with mental health use; the lack of faith in the benefit of hospitalization; tendencies to keep family members in the community; differential knowledge, differential access, and use of alternative services (Snowden & Cheung, 1990). For example, African-Americans have been found to associate a stigma with the use of mental health services; to have lower expectations of the benefit of treatment; to experience a fear of being institutionalized; and to have limited awareness of how to access existing services (Takeuchi et al., 1993; Snowden & Cheung, 1990; Sussman et al., 1987).

Several researchers have noted racial and ethnic differences in mental health service use. Differences between African-Americans and Caucasians have been documented as far back as 1914 (Fried, 1975). Studies have reported a higher rate of mental health service use (Padgett et al., 1994) and an over-representation of African-Americans in inpatient care (Sue, 1977). Other studies of ethnic service use have included reports on Hispanic-American and Mexican populations (Lopez, 1981) with few reports on Asian-Americans (Kitano, 1982). These groups have been found to have lower utilization rates than Caucasians (Snowden & Cheung, 1990). In 1969, Kitano found the hospitalization rates of Chinese and Japanese persons to be lower than other ethnic groups. Similar findings were found thirteen years later when Kitano (1982) reexamined these populations.

Rosenstein, Milazzo-Sayre, MacAskill and Manderscheid (1987) illustrate the differential patterns of mental health use by Caucasians and ethnic minorities in a comprehensive study. These researchers found African-Americans to have higher mental health utilization rates in public sector federal and non-federal hospitals. County hospital utilization rates per 100,000 were 36.8 for Caucasians; 364.2 for African-Americans; 306.4 for Native-Americans/Alaskan Natives; 146 for Hispanic-Americans; and 75.4 for Asian-Americans. Similar utilization patterns were illustrated for Veteran Administration Centers and psychiatric hospitals.

There is a gap in available data concerning mental health service use for minority youth. The available data indicate that similar to adults, children and adolescent service use patterns have also demonstrated differences according to ethnicity. Rates of outpatient use by minority youth decreased from 1975 to 1986. Conversely, outpatient utilization rates increased among Caucasian youth (Hoberman, 1992). Gibbs (1989) reported that African-American youth were over-represented in state, county and general hospitals and were under-represented in private psychiatric facilities. Although Burns (1991) reported minority mental health service use was in proportion to their representation in the population, she found minorities to have elevated use of partial hospitalization services. Unfortunately, these data did not provide a breakdown according to specific minority groups. As a result, Burns (1991) provides a caveat that these findings may not remain constant across specific minority groups.

The available literature suggests ethnic differences in mental health

care-seeking. In most instances, minority groups tend to utilize services at a lower rate than Caucasians. Also, minorities have been found to have shorter stays in treatment than Caucasians (Cheung & Snowden, 1990). African-Americans have been found to frequently drop out of treatment (Armstrong, Ishiki, Heiman, Mundt, Womack, 1984). Similar disruptions in services have been noted for Hispanic-Americans, Asian-Americans, and Native-Americans. However, data regarding these ethnic groups is less complete (Cheung & Snowden). The majority of studies regarding care-seeking have focused on adults with few reports which describe the utilization patterns of minority youth.

Ethnicity and Need for Mental Health Services

It has been suggested ethnicity may have multiple influences on the mental health of youth. Ethnicity may affect the manner in which youth manifest symptoms and coping behavior, beliefs about treatment, utilization and response to treatment. Combined with membership in a minority group, ethnic identity can create a significant challenge to a youth, particularly when that race is visibly identifiable by skin color (Gibbs & Huang, 1989). Racial discrimination manifested through stereotypes, treatment as inferior or unequal, and threats or insults can function as risk factors for a variety of negative behavioral and emotional outcomes (Toomey & Christie, 1986). There appears to be a significant interrelationship between ethnicity, race and social class in the United States, which can influence individuals' mental health. For example, high status is associated with membership in Caucasian, Anglo-Saxon, middle-class families while low status is associated with membership in non-Caucasian, ethnic minority,

lower-class families (Gibbs & Huang, 1989). Lower socioeconomic status (SES), particularly poverty, may render a negative impact on mental health, primarily through exposure to increased rates of stressors (Toomey & Christie, 1986). Given the clear association between minority race and lower SES, rates of psychiatric disorders among minority youth might be expected to be higher than those of Caucasian youth. Thus, children of color are doubly disadvantaged by ethnicity and related poverty. Other risk factors for psychiatric disorders for children and adolescents include living in foster care, living on welfare, prolonged parent-child separation, physical or sexual abuse, catastrophic events, bereavement, marital discord and family instability, low birth weight, and fetal alcohol syndrome or effect (Institute of Medicine, 1989). Few studies have examined the degree to which minority youth are described by these identified risk factors for psychopathology.

Ethnic-related Differences in Child and Adolescent Psychopathology

There is little evidence which demonstrates a greater lifetime prevalence of psychiatric disorders related to minority status for adults even when socioeconomic status is controlled (Robins, Helzer & Weisman, 1984). Most epidemiological studies of children and adolescent psychiatric disorders have either failed to stipulate the ethnicity of persons in the sample or simply did not include youth of color (Hoberman, 1992). Less than 8% of the sample in the three epidemiological studies conducted in the United States were minority youth. Definitive data regarding psychiatric illness among minority youth is lacking (Bird et al, 1987; Cohen, Velez, Kohn, Schwab-Stone, & Johnson, 1987; Kashani et al,

1987; McGee et al., 1990; Offord et al., 1987; Whitaker, Johnson & Schaffer, 1990). Although it is difficult to generalize the extent of mental health problems in minority youth given the limited studies in this area, the following sections highlight issues related to child and adolescent psychopathology for (1) African-Americans (2) Hispanic-Americans (3) Asian-Americans and (4) Native-Americans.

African-Americans

Most of the investigations of the mental health of African-American youth have been conducted in either community surveys or clinical sites. Examinations of depression among African-American youth report higher rates of depression among males and lower income youth (Gibbs, 1989); however, no significant differences were found when controlling for age, SES and gender (Kaplan, Hong, & Weinhold, 1984; Gibbs, 1990). Other studies have found African-American males to be proportionately under-represented among adolescents in school clinics who were identified as depressed (Stiffman, Earls & Robins, 1988). Although the prevalence of conduct disorders is unknown, school conduct and delinquency problems have been found to be disproportionately higher among African-American males (Hoberman, 1992; Gibbs, 1989). Also, African-American males have been found to make up more than 23% of juvenile arrests, more than 26% of juveniles in residential facilities (Gibbs, 1989) and have four times the risk of Caucasian youth to be in correctional institutions. Furthermore, this group has been found to have a psychiatric hospitalization rate two to three times the rate of Caucasian youth.

Community surveys of drug and alcohol use have revealed African-American youth have a lower prevalence of alcohol use than Caucasians and they may have a later onset of drinking (Hartford, 1985; Dembo, 1988). Brunswick's (1980) report of African-American youth's drug use found African-American youth initiate drug use at an earlier age and use cocaine and heroin drugs more often than Caucasians although equal rates of marijuana use were found for both groups. Rates of cocaine and heroin use have increased among African-Americans and Caucasians. Similarly, suicide rates have tripled and doubled for African-American males and females respectively (Heacock, 1990). Nevertheless, attempted suicide reports of African-American males appear to be under-represented (Heacock, 1990; Liu, Yu, & Chang, 1990).

Hispanic-Americans

Literature regarding the use of mental health services by Hispanics (such as Mexican-Americans and Puerto Ricans) indicates they tend to have lower utilization rates than Caucasians. Contrarily, Hispanic-Americans tend to have higher rates of depressive symptoms than African-American or Caucasian youths. Studies of disorders among Mexican American youth prior to 1980 reported a lower prevalence of mental disorders as compared to other groups. However, studies after 1980 reported prevalence rates were higher or at least comparable to the overall population (Ramirez, 1989; Robert, 1980). Ramirez (1989) conducted an informal analysis, which compared diagnoses given to Mexican Americans and non-Mexican-Americans seeking help from a community guidance center. The researcher found Mexican-Americans were as likely to be diagnosed with conduct

disorders of the aggressive subtype. Mexican-Americans who reside in small towns have been found to have severe and elevated rates of alcohol and drug use (Chavez & Roney, 1990). Other empirical research has shown Puerto Rican youth have higher rates of psychiatric disorders than Caucasian adolescents (Inclan & Huran, 1991). Hispanic-American female adolescents were found to account for 25% of patients admitted to the hospital for suicidal behavior, a much higher rate than expected according to their representation in the population (Razin, O'Dowd, & Nathan, 1991). In general Hispanic-Americans have low rates of suicide. However, there is evidence suicide rates among Hispanic-Americans have increased in recent years (Chavez & Roney, 1990). Reports also indicate Puerto Rican males have reportedly higher rates of suicide compared to African-Americans and Caucasians.

Asian-Americans

Few studies explain and describe the mental health problems and utilization patterns of Asian-Americans. However, estimates of Asian-Pacific adolescents' treatment prevalence indicate their age-adjusted commitments to psychiatric hospitals and correctional facilities are approximately half the rate of Caucasian youth (Liu et al., 1990). Differences also exist among Asian-Americans. For example, surveys in Asian-American communities have found Chinese refugees from Southeast Asia are twice as likely to need mental health services as non-refugee Chinese. In addition, Cambodian refugees have also been found to have extraordinarily high mental health needs (Williams & Westermeyer, 1983). Data are limited which depict depression or anxiety disorders among Asian-

American youth in general, but Yates (1987) has reported high depression scores for Asian-American adolescent refugees. The number of Asian-American suicide deaths accounts for a much larger proportion of deaths than among Caucasians (Liu et al., 1990).

Native-Americans

In general, Native-American youths' rates of mental health disorders are similar to Caucasians. In early adolescence, however, there is a sharp increase in the number of youth with mental health problems (Yates, 1987). Findings from several studies indicate Native-American adolescents have high rates of alcohol and drug abuse (Beauvais, Oetting & Wolf, 1992; Okumabua & Duryea, 1987). Similarly, Native-Americans' onset of alcohol and drug use is generally higher than other adolescents. LaFromboise & Low (1988) found that compared to other ethnic groups, Native-Americans' rates of delinquency and arrests are extremely high. Reports by Rosen, Shafer and Dummer (1988) cite an increase in eating and weight disorders among Native-American youth. The rates of attempted suicide by Native-Americans are almost double the rate for Caucasians: 12% for males and 20% for females (Blum, Harmon & Harris, 1987). Also, Native-American youth have a higher rate of completed suicides than any other ethnic group and their rate is almost double that of Caucasian youth (Wyche & Rotheram-Borus, 1990).

The Impact of Socioeconomic Differences and Mental Illness

Some researchers suggest socioeconomic status is correlated with severe mental illness (Cheung & Snowden, 1990). Given the correlation between SES

and minority status, socioeconomic characteristics have been cited as an explanation of differences in inpatient use between minorities and Caucasians. However, limited data exist which demonstrate racial differences in inpatient use are explained merely by socioeconomic factors (Robins, Helzer, Weissman, Orvaschel, Gruenber, Burke & Regier, 1984). Contrarily, researchers have found minorities to have higher inpatient use when socioeconomic status has been controlled (Snowden & Cheung, 1990). In one study of racial differences in hospitalization among severely mentally ill persons, African-Americans were found to be hospitalized significantly more frequently than Caucasians (Snowden & Holschuh, 1990). This difference remained significant when the researchers adjusted for equal access to supportive community services and controlling for previous hospitalizations, diagnosis, socio-demographic variables and amount of time in the program. The researchers concluded socioeconomic variables by themselves were incomplete explanations for differential utilization patterns. Scheftler and Miller (1989) who examined hospitalization patterns of African-Americans, Caucasians, and Hispanic-Americans, reported similar findings. When the variables of age, income, and cost of service were held constant, African-Americans were 23.5% more likely to be hospitalized than Caucasians and Hispanic-Americans. In addition Hispanic-Americans were 13.5% more likely than Caucasians to be hospitalized. Data from these studies suggest some of the ethnic differences in hospitalizations cannot be merely attributed to socioeconomic differences. Given limited direct evidence and the unique distribution of income among racial and ethnic groups and their rates of

hospitalization, it appears socioeconomic explanations by themselves only partially account for differences in use of restrictive services.

Clinical Factors and Societal Reaction to Mental Illness

In 1984, Rosenfield examined race differences in psychiatric hospitalization by testing propositions from the psychiatric perspective and the labeling perspective of mental illness. According to the psychiatric perspective, higher rates of involuntary psychiatric hospitalizations among non-Caucasians would be attributed to more severe mental health need among non-Caucasians or non-Caucasians' less favorable attitudes toward treatment care (Rosenfield, 1984). This study contributed to research regarding race differences in involuntary hospitalization by controlling for clinical condition and social class. The study consisted of a random sample of 666 individuals from a psychiatric emergency room in New York City. The decision for hospitalization was measured using type of treatment which involved either hospitalization (which covers all inpatient facilities) or non-hospitalization. The decision for hospitalization further specified whether the hospitalization was voluntary or involuntary. Psychiatric condition was measured by the diagnoses given by the interviewing psychiatrist according to the 1980 Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. The researcher compared the relative proportion of Caucasians and non- Caucasians who were hospitalized voluntarily, as compared with involuntary hospitalization, controlling for diagnosis measured attitudes. Social distance was investigated by comparing the social characteristics of patients with those of the interviewing psychiatrists. Patients and physicians were

compared in terms of both race and sex. Paths to treatment were indicated by how patients came to the emergency room, specifically whether they came by themselves, with family or friends, through other treatment personnel, or by the police. Rosenfield conducted analyses to determine the likelihood of hospitalization in general, likelihood of inpatient hospitalization vs. voluntary hospitalization and the likelihood of involuntary hospitalization vs. all other type of hospitalizations. In the first analysis of hospitalization in general, dependent variables were coded as one for more severe reactions and two for less severe societal reaction. The lower the mean score, the greater the frequency of hospitalization. In the second analysis, the likelihood of involuntary hospitalization, a code of one was provided for involuntary hospitalization and two for voluntary hospitalization. The lower the mean score, the greater the likelihood of involuntary hospitalization. In the last analysis involuntary hospitalizations were coded as one and all others were two. Therefore, the lower the mean score, the larger the percentage of all patients who are involuntarily hospitalized.

Rosenfield did not find whites and nonwhites to differ in the likelihood of hospitalization in general, or in voluntary hospitalization. However findings from the study revealed non-Caucasians, with a mean score of 1.67 were significantly more likely than Caucasians whose mean score was 1.80, to be involuntarily hospitalized. In addition, the relationship between race and involuntary hospitalization remained when type and severity of disorder were controlled ($p=.017$). After examination of both psychiatric condition and attitudes toward

treatment as psychiatric explanations for race bias in involuntary hospitalizations, neither was found to account for higher rates among non-Caucasian males. The only variables found which explained greater involuntary hospitalizations for non-Caucasian males were pathways to treatment. The more coercive conditions under which non-Caucasians entered treatment determined the more severe responses to non-Caucasians' deviance. The labeling perspective of ethnic differences in involuntary hospitalization was supported. Based on these findings the author concluded her analysis yielded support to the labeling perspective.

In another study, Mechanic and colleagues Angel and Davies (1991) employed the labeling perspective to examine risk to society and selection processes between general medical providers (i.e., physicians) and mental health specialists (e.g., psychiatrists, psychologists). The rationale for the study was the researchers' contention that diagnosis or clinical severity were poor measures of service use. Instead, the authors suggested the social impact or societal risk of a mental disorder determined referrals. Risk was defined as the threat of danger or disruption of an individual's behavior. The researchers explored the hypothesis that the risk associated with mental disorder increases the probability of referral of patients receiving mental health care from general medical practitioners to the mental health sector.

Data for the study were derived from interview and claims data from the RAND Health Insurance Experiment (HIE). The RAND experiment is a large experimental study of coinsurance which was conducted from 1974 to 1982. This study included a sample of 3,738 enrollees from 18 to 61 years of age. Labeling

theory was employed as a framework to illustrate how the social context of evaluation or societal reaction makes risks more or less significant. According to Mechanic and colleagues, the notion of risk of danger is implicit in virtually all illustrations of how labeling takes place.

Mechanic and colleagues compared persons with and without mental health visits and persons with mental health visits exclusively with medical practitioners to other types of referrals. Suicidal thoughts, legal problems, deviant sexual behavior, drinking problems, depression, general health index and life events were employed as measures of risk.

Findings indicated the majority (57%) of persons with a mental health visit did not have an appointment with a specialty provider. However, persons with at least one mental health visit were significantly more likely to report suicidal thoughts than those who did not have these visits. Also, persons with a mental health visit were more likely to have legal problems, to have experienced more life events, and to have higher depression scores than persons with no mental health visits. No significant differences were found between the two groups in regard to drinking problems or deviant sexual behavior.

Logistic regression revealed suicidal thoughts and drinking problems helped to explain selection into the specialty mental health sector. These findings suggest issues of risk increase the probability of referral, and suicidal thoughts are associated most strongly with the probability of a visit to a specialty provider. Subsequently, the results supported the notion that there is a need to measure risk and disruption more specifically as a factor affecting referral to mental health

specialty care.

Limitations/Problems Related to Diagnosing Mental Illness

It has been suggested gatekeepers may perform diagnostic assessment in a manner which imposes unfair assignment to inpatient care (Snowden & Cheung, 1990). Similarly, racist theories and attitudes in the mental health system may influence the pathways to and use of psychiatric facilities, as well as the differential use of diagnostic criteria and labels. There is some evidence that African-American juvenile delinquents have received differential treatment in the mental health system. For example, studies have indicated a Caucasian juvenile offender is often assessed as having a psychological problem. On the other hand, the psychological problems of an African-American juvenile offender are typically "undetected, undiagnosed, and untreated (Gibbs, 1990, p. 29). This is problematic because of the high rates of depression and psychological symptoms among African-American juvenile delinquents (Dembo, 1988).

Several researchers have examined the influence of race in the assessment and diagnosis of mental illness. Jenkins-Hall and Sacco (1991) found therapists held more negative evaluations of depressed than non-depressed clients, and the combination of being African-American and depressed led to the most negative evaluation. Caucasian therapists have been found to generally rate their African-American clients as more psychologically impaired than African-American therapists. Other studies have indicated Caucasian professionals may misconstrue uncooperative behavior among Hispanic-Americans as evidence of psychosis (Rendon, 1974; Smith Kline Corporation, 1978) and professionals' lack of

knowledge of Puerto Rican culture is likely to lead to misdiagnosis (Teichner, Cadden, & Berry, 1981). When diagnosed with psychotic or affective disorders, minority-race clients are more likely to be labeled as having a chronic syndrome than an acute episode (Sata, 1990).

Data from a longitudinal study by Franshel and Shinn (1978) suggested racial bias was an important factor along with other socioeconomic factors such as poverty. These researchers found differences between minority and Caucasian youth remained constant when other variables (economic status, family situation and offense histories) were controlled. Stehno (1982) also suggests racial bias may be the primary reason for the differential treatment of minorities and Caucasians. Stehno (1982) studied national data to compare placement of minority and non-minority youths. Significant findings indicated the following: higher rates of out-of-home placement among minority adolescents than Caucasian adolescents; different patterns of referrals for African-American and Caucasian youths; a disproportionate number of minority children in fewer desirable placements; greater proportions of African-American youth served in the public sector rather than in the private sector; and less social service support received by minority parents than by non-minority parents.

Problems of overdiagnosis of schizophrenia and underdiagnosis of affective disorders persist. This is particularly the case for African-Americans and persons of lower socioeconomic status (Jones & Gray, 1986). Researchers Jones and colleagues (Jones & Gray, 1986; Jones, Gray, & Parsons, 1981) examined the issue of bias in diagnosis in studying the differential diagnosis of affective

disorders versus schizophrenia among African-Americans. The researchers maintain affective disorders may be underdiagnosed and schizophrenia may be overdiagnosed among African-Americans. Findings from their study indicate higher rates of manic- depressive disorders among African-Americans. Diagnostician bias in favor of schizophrenia as a label for African-Americans is consistent with national data regarding patterns of admitting diagnoses to inpatient care. National rates demonstrate relatively high rates of schizophrenia among African-Americans and low rates of affective disorders (Jones & Gray, 1986).

Very little research has been conducted regarding the problem of diagnostic bias for Asian-Americans, Hispanic-Americans, and Native-Americans. However, it is likely that overdiagnosis of some categories and underdiagnosis of others occurs for these populations (Snowden & Cheung, 1990).

Stigma of Mental Health Service Use

The use of mental health services has been traditionally viewed with shame and embarrassment. Gans et al. (1991) identified an individual's real or imagined fears about his/her child's reputation were important barriers to parental use of mental health services. In a study of attitudes of mental help-seeking Leaf, Livingston and Tischler (1986) found one-fourth of the respondents believed their family members would be upset if help was sought for emotional problems. Consequently, anticipation of upsetting a family member was reported to be significantly related to lower service use. Parents in rural areas encounter barriers to mental health services posed by traditional community mores and perceptions

of mental illness. Previous treatment etiologies which tended to blame the parent or family for the child's problems are other factors which have influenced parental use of child mental health services (Knitzer, 1993).

Referrals

Available epidemiological data for psychiatric conditions for Caucasians and minority youth indicate a significant need for mental health services. Yet, compared to adults, very little has been written concerning the care-seeking patterns of adolescents and children. This may be due to the fact that adolescents and children normally do not make the decision to seek care. Quite often, it is an adult (i.e., teacher, parent, and guardian) who makes the decision to seek care on their behalf. The referral process is a key component of mental health utilization. Little data exist regarding adolescents' ability to recognize psychiatric symptoms as constituting a psychiatric disorder, which might be amenable to treatment. Boyle, Offord, and Hoffman (1981) showed the overall prevalence of perceived need by parents for professional mental health care for adolescents was less than 7%. According to Hoberman (1992), their parents do not recognize two-thirds of youth with diagnosable conditions. Similarly, McGee and others (1990) found parents agreed with their children only 50% of the time regarding the child's mental health problems.

Primary care physicians have not been found to have a significant role in the recognition of psychiatric disorders among adolescents. This is likely due to the fact that adolescents have the lowest rate of physician contact of any age group in the United States. African-American youth have been reported to have less

physician contact than Caucasian adolescents and are even less likely to be referred to treatment by physicians.

Agencies which may have a significant role in the identification of mental health problems for adolescents include public schools and the juvenile justice system. Unfortunately, there are limited data that demonstrate either of these institutions' ability to recognize or intervene with adolescents with psychiatric disorders. Among the population of school-enrolled youth who are viewed as emotionally disturbed, only 57% are identified and receive services (Knoff & Barsche, 1990). Ethnicity has been found to have a powerful influence on the identification of students in need. Quite often, African-American students are heavily identified as in need of mental health interventions while Native-American and Asian-American students are rarely identified as in need of mental health interventions.

Studies have revealed that relatively few youth with mental health problems are referred to, or receive, mental health services. Takeuchi et al. (1993) found that individuals outside of their family commonly refer African- American youth to treatment. Contrarily, parents or family members of Hispanic-American youth were found to seek care on their behalf. Klier, Lepore, Broquet, and Zuba (1990) examined care-seeking in older aged children and Kurtz, Jarvis and Kurtz (1991) explored the care-seeking behavior of homeless youth. Other research which has examined care-seeking among adolescents and children includes research of suicidal youth (Windle, Miller-Tutzauer, Barnes & Welte, 1991), adolescent drug users and delinquents (Takeuchi et al., 1993), youth with behavioral disorders

(Institute of Medicine, 1989) and minority adolescents (Bui & Takeuchi, 1992).

A study by Takeuchi and colleagues (1993) examined whether African-American adolescents and Mexican American adolescents were more likely to enter the mental health system through a different referral source than Caucasians. A sample of 2,460 adolescents ages 13 to 17 was drawn from the Los Angeles Department of Mental Health Automated Information System. Referral sources were measured by 40 different levels, which fell into one of four broad categories that included family, social agency, school or health sector. Since socio-demographic factors relate to mental health service use, the researchers controlled for gender, age and poverty status. Significant findings revealed ethnic differences between African-Americans and Caucasians. Similarly, Mexican-Americans were also found to be poorer than Caucasians. All groups were found to be referred to mental health services by sources other than family or friends.

Researchers have examined the referral process for mental health services from several perspectives. This process is fundamentally different for adults than it is for children. Typically, the referral process is more coercive for youth than adults, primarily because children are minors in American society and the responsibility for their well-being rests with adults. Unless it is mandated, adults can seek mental health care on a voluntary basis (Takeuchi et al., 1993). Furthermore, when they are referred to treatment, they can elect not to follow through with treatment. On the other hand, youth have few, if any, choices. They primarily enter the mental health system because their families or an

external agency decides their behavior warrants an intervention. Although others may have a significant role in determining an adult's behavior as deviant, the adult must recognize and, to a degree, accept the diagnosis and get help (Takeuchi et al., 1993). Accepting the label is not a part of the referral process for most youth. The decision to get help is made by others who define his/her conduct as deviant and subsequently refer the child to treatment. Generally a referral is made because the youth's behavior or emotional problem is disruptive or threatens harm to some social unit (Mechanic et al., 1991).

Generally, children and adolescents lack both the legal and social status to make decisions about their well-being without adults. As a result, several audiences monitor their behavior. Often, these audiences have different perceptions of the problem behavior (Takeuchi et al., 1993). For example, some families may resist seeking professional help for their children because they view the problem behavior as "normal," and unrelated to a mental health disorder, or families may associate a stigma with mental illness (Katz-Leavy, Louries & Kaufmann, 1987; Sue & McKinney, 1975). On the other hand, external agents such as schools and social service agencies may interpret the youth's behavior as warranting mental health intervention. While families may be unaware of mental health programs, external agents are likely to recognize them.

Availability of Mental Health Services

The under-use of child mental health services has been attributed to the small number of psychologists or psychiatrists who specialize in the treatment of child and adolescent psychiatric disorders (Knesper & Pagnucco, 1987). Slightly more

than 10% of psychiatrists and less than 1% of psychologists are primarily devoted to serving children and adolescents (Tuma, 1989). Several researchers have noted the lack of availability of less restrictive services (Knitzer, 1982; Bickman et al., 1992). This has been for both rural and urban areas. Rural dwellers often suffer from having an inadequate amount of services available while urban dwellers tend to experience a lack of non-restrictive service alternatives. In a study by Tarico and others (Tarico, Low, Trupin, & Forsyth-Stephens, 1989), parent interviews revealed that 73% of the parents encountered problems with the availability of services for their children. The accessibility of services is a barrier in both rural and urban service areas. Geographic dispersion creates transportation problems for rural dwellers while densely located services pose problems of access for urban dwellers (Cohen & Hesslebart, 1993).

Financial barriers to child mental health services are common for poor, uninsured and non-Caucasian children (Wood, Hayward, Corey, Freeman, & Shapiro, 1990). The propensity for Caucasians to earn higher incomes and consequently have more insurance coverage often minimizes their risk of affordability barriers. Stefl and Prosperi (1985) found affordability was the most common barrier to service use. Wood et al. (1990) used a multistage design to examine access to care for 2,182 children and adolescents in a study funded in part by the Robert Wood Johnson Foundation. The researchers found that having medical insurance and having seen a doctor in the past year were indicators of access and facilitated service use. Also, non-Caucasian children were found to have less access to care regardless of health status.

Funding for mental health services is directly related to the issue of service affordability. Having health insurance has been found to be significantly related to service use (Stefl & Prosperi, 1985); therefore, it is useful to note that children and adolescents represent one third of the 31 million Americans who do not have health insurance (Hoberman, 1992). Although access for poor children has been improved by Medicaid, the primary source of health care financing among children and adolescents from low-income families (Gans, McManus, & Newacheck, 1991), it has not eliminated disparities in the ability to obtain medical care. Despite the increase in poverty levels, the number of persons with Medicaid coverage has decreased (Hoberman, 1992). During the 1970s, Medicaid covered approximately 75% of the country's poor children; however, after program cuts in the 1980s it now covers about half of poor children and adolescents. In addition, Medicaid's mental health benefits to children remain highly restricted to those children who are severely ill (Hoberman, 1992). Recently, in some states there have been improvements in the expansion of the mental health services for children who are covered by Medicaid. For families with private health insurance, simply having insurance does not necessarily translate into coverage for mental health services. Private insurers often place restrictions on enrollees as to the number of visits that will be covered and often enforce high co-payment and payment caps. As a result of these barriers, minority children and adolescents are more likely to experience multiple barriers and problems of access than Caucasian children (Toomey & Christie, 1986).

Summary of Literature Review

The review of literature examined issues related to mental health service use for youth. Given the lack in literature for minority youth, reports regarding adults were also examined. Study samples were generally from clinic, school or community samples. Some of the factors have been identified with individuals' use of mental health services include: patients' attitudes and illness behavior, physicians' recognition of mental disorders and their attitudes toward them; and the social, economic and physical accessibility of mental health services (Huxley, 1980; Mechanic, 1989; Goldberg, 1990).

Several researchers have reported higher use of inpatient service use and more involuntary mental health hospitalizations among minorities. Explanations provided for these differences are: differences in socioeconomic status; differences in prevalence of major psychopathology; stigma of mental health services use; greater capacity, tolerance or support for dysfunctional significant others; differences in access and use of alternative services; and bias in the behavior of gatekeepers, (particularly practitioners assigning diagnostic labels and making involuntary commitment decisions) (Snowden & Cheung, 1990). A limited amount of literature explores these explanations in mental health services for youth.

Socioeconomic factors, access and financial barriers were also found to impact mental health service use for minorities and Caucasians. Ethnic differences in care-seeking appear consistent throughout the literature. In addition, ethnic differences have also been found for referrals to mental health services. A need

for mental health service use was found among all ethnic groups along with problems of over-and under-diagnosis for certain groups.

Minority youth are the fastest growing segment of the population. It is projected that by the year 2040, youth of color will constitute 40% of the nation's youth population. These statistics combined with the consequences associated with ethnic minority status give support to the need for more research to examine mental health issues for minority youth. There is a lack of research which describes the factors that affect placement, referral and length of service for youth in the mental health system. This study examines these issues for African-American and Caucasian youth.

Chapter III

METHOD

Data

This historical cohort study is a secondary analysis of data collected under the Comprehensive Services Act (CSA) in Virginia from July 1993 through June 1996. The primary purpose of the CSA is to "create a collaborative system of services and funding that is child-centered, family-focused and community-based when addressing the strengths and needs of troubled and at-risk youths and their families" (Comprehensive Services Act, 1993). The source of data for this study is the Comprehensive Services Interim Data and Evaluation (C-SIDE) System, a management information data system (MIS) maintained by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. The C-SIDE system is designed for the management information, monitoring, and evaluation of the Comprehensive Services Act (CSA). A total of 6,005 children and youth in the C-SIDE system received services through the CSA from July 1993 through June 1996. Data elements in the minimum data set are routinely collected when youth are enrolled in the CSA and are submitted by local Family Assessment and Planning Teams (FAPT). Only those FAPTs which submitted data for the entire study period were included in the analysis. The data set includes descriptive data about youth, as well as administrative data regarding the services provided through the CSA.

The minimum data set includes the following elements: the youth's name, social security number, date of birth, gender, and race. Other elements in the

minimum data set include: county code, the date the information was entered, the family assessment planning team (FAPT) identification number, referral date, CSA enrollment/intake date, the population type, whether the youth was court ordered to service, the primary referral source, whether the youth had been placed out of the home during the 12 months prior to enrollment in the CSA, the type of out-of home placement prior to CSA, the number of days in out-of-home placement, the educational placement of the youth at enrollment and the presenting problem(s) of the youth. This information is typically collected on standardized forms by the youth's case manager and is then entered into the C-SIDE system. The information is verified by the Family Assessment and Planning Team (FAPT) assigned to the youth's case. The FAPT team consists of representatives from the following fields: mental health, social services, court services, public health and the educational system. There is also a parent representative on the team and often a private service provider. The team reviews referrals of youths and families, provides for family participation, develops individualized service plans, makes referrals to services, recommends expenditures from the Local Funds Pool and designates case management responsibilities.

Extensive treatment and service data files containing the type of service and funding source are retained for each client. These files have been merged and services have been matched according to identification number. These data were then placed into an SPSS-X format for use in data analysis using SPSS-X version 7.5.

Sample

The sample in this study included youth who receive services through the CSA. Children and youth eligible to receive services under the CSA have serious emotional or behavioral problems, which require the intervention of more than one agency. Priority is given to those who are in or at risk of going into out-of-home placement. The act also targets young children at risk of later development of serious emotional or behavior problems. The Departments of Mental Health Mental Retardation and Substance Abuse Services, Youth and Family Services, Social Services, and Education serve children and adolescents eligible for services under CSA.

This study was limited to youth ages 10 to 19 years old. The original study sample consisted of 3,849 cases. The following exclusions were made to the sample: (a) any cases that had missing values in the critical fields; (b) cases with invalid dates or categorical values; and (c) persons other than African-Americans and Caucasians. Once these exclusions were made the sample consisted of n=2,883 cases.

Human Subjects Protection

This study was reviewed and approved by the Human Subjects Review Committee at Old Dominion University. This data set includes sensitive information regarding children and youth; the greatest potential risk would be the release of this confidential information or the use of this information for purposes other than research. In order to protect from risk the children in this study who received services under the CSA, the data have been client-protected. No

information pertaining to an individual's name, address, or other identifying information is included in the data set. Therefore, there are no identified potential risks to youths who have been served under the CSA and included in this study. Any reports generated from this work will be presented in aggregate form.

Written permission to utilize the CSA minimum data set was granted from the Office of Comprehensive Services Act Evaluation in the Virginia Department of Mental Health Mental Retardation and Substance Abuse Services. These data will not be utilized for any other purpose than research, and were handled with confidentiality.

Data Quality

The validity and reliability of secondary data taken from treatment records and administrative databases are often difficult to assess. However, researchers have demonstrated the effectiveness of these data in previous investigations of minority health issues (Takeuchi, Bui, & Kim, 1993; Cheung & Snowden, 1990; Hu et al., 1991; O'Sullivan et al., 1989; Snowden & Cheung, 1990; Sue & McKinney, 1975). In order to assess the accuracy of the data, data cleaning was performed. Data cleaning involved cross-checking data to insure consistency of information, and range checking of date and categorical fields. Tests to identify missing data points and duplicate cases were also performed. Given the purpose and scope of the study, several data points were identified as critical to the research questions and data analysis. These data points were date of birth, race, gender, client county code, intake date, presenting problem, service beginning date and service end

date. Errors or omissions in any of these fields were deemed to constitute a "fatal error." Subsequently, cases with fatal errors were not included in the sample for data analysis.

In order to determine the validity of data in categorical fields, tests were employed to determine the accuracy of values for the identified critical fields. Invalid values were identified only for two fields. The correct value for the gender field was either an "M" for male or an "F" for female. Gender fields contained one value ("U") that was out of range. The proper categorical values for the Hispanic-American field was either "Y" for yes or "N" for no. There were three values which were out of range: "Q," "U," and "X." These characters represented less than 2% in the data set.

The validity of dates for critical fields for birth date (DOB), disenrollment date (DISDATE), and CSA enrollment date (INTAKE) was determined by one of two indicators: (1) comparing the entered date with a calendar date; and (2) comparing dates that were within the month, day, and year of CSA implementation. All dates of birth were valid calendar days. There were three CSA enrollment dates that were not within the month, day, and year of CSA implementation: "January 15, 1982"; "May 2, 1983"; and "February 1, 1984." These dates were out of range because they were prior to the CSA implementation date.

Data Limitations

Primary data collection such as those abstracted from treatment records or in a prospective study would have been the preferred method of data collection for this study. However, primary data collection was not a feasible option. As a

result, there are certain data elements which the researcher could not assess. The primary limitation of this data set in relation to the purposes of this research is that information regarding household, family income, insurance status, family size or socioeconomic variables were not available. In addition, neither zip code nor census tract data were available. Had these data been available, they would have been utilized as a proxy for household income. In the absence of data regarding income, the median income from the child's county was proposed as a proxy for individual income. However, initial analysis revealed this variable was highly skewed and not a reliable measure appropriate for individual units of analysis. The lack of a measure of income made it impossible for the researcher to adequately control for socioeconomic status.

Missing Values

The general completeness of the data was fair. However, there were several minor inconsistencies in the entering of data that were reviewed and corrected by visual inspection and data management. Missing values were identified for several variables in the data set; however, the number and percentage of missing values for critical variables in the study sample were low. The number and percent of missing cases in the C-SIDE database for the identified critical fields are listed in Table I.

Measures

The outcome measures in the study are: 1) the source of referral at the time of enrollment; 2) length of service; 3) whether the youth was placed out-of-home prior to CSA enrollment; 4) whether or not the youth had a residential

Table I

Missing Data Points for Critical Variable Fields

Variable	Number	Percent
Ethnicity	55	1.4%
Date of Birth	None	None
Gender	25	.6%
Residence	13	.3%
Referral Source	29	.8%
Intake Date	None	None
Presenting Problem	None	None
Total	122	3.1%

placement; and 5) length of service in CSA. Primary referral source is item 10 on the minimum data set form (Appendix 1). The level of measurement of this variable is nominal with the following categories: self, family/friend, clergy, judge, attorney, court service unit, police/sheriff, state hospital, private hospital, community services board, school system/educational agency/teacher, department of social services, department of health, homeless shelter, formal multi-agency referral, and other. For this study, the referral source was recoded into four general categories: 1) informal referral--family, friend, self; 2) social agency--probation department, children's services, etc.; 3) school; and 4) health-mental health professionals, community services boards and other health entities. This classification is similar to that employed by other researchers (Takeuchi, Bui, & Kim, 1993). This variable was collapsed in the multivariate analysis as informal referrals (family, friend, self) denoted by 0 and formal

referrals (social, school, health) denoted by 1. Whether the youth had an out-of-home placement prior to CSA was coded as "0" for no, and "1" for yes. Information regarding whether the youth had a residential placement was taken from the service file. It is a dichotomous variable, 0 represents no and 1 denotes yes. Length of service was computed by subtracting the service start date from the service end date.

Study Variables

Other variables in the study were age, sex, ethnicity, primary and presenting problems.

Presenting problems. "Presenting Problems of Youth" which includes a list of 23 categories, is item 14 on the CSA minimum data set form. This variable indicates the presenting problem of the youth at the time of enrollment. The presence of problems is determined by a clinician during the youth's intake evaluation. Presenting problems are also reviewed by the family assessment and planning teams (FAPT). The presenting problem or problems are determined by a team of clinicians based on information derived from the intake interview, the child's social history, and assessment checklist. Since each child potentially may have more than one problem, there were actually 23 separate variables. Presenting problems include mental retardation; developmental disability; substance abuse; serious emotional disturbance; autism disorder; delinquency/court involvement; acting out behavior (e.g., runaway, curfew, incorrigible); truancy; learning disability; poor academic performance; physically/emotionally abused; sexually abused (youth is the victim); sexually abusive (youth is perpetrator);

neglected; physical disability; visual/hearing impairment; traumatic brain injury; speech/language disorder; chronic health problem; pregnancy/parenthood; attention deficit hyperactivity disorder (ADHD); aggressive behavior and other. The presence of the problem is denoted by "1" and the absence is denoted by "0." Guidance was received from a licensed clinical psychologist whose specialty was child psychology in order to collapse the 23 presenting problems into the following categories: Cognitive/neurobehavioral problems, abused youth, delinquency, health and substance abuse problems. Specifically, the problems were grouped as follows:

Cognitive/neurobehavioral. These problems include: mental retardation, developmental disability/delay, autism, learning disability, poor academic performance, speech/language impairment, attention deficit hyperactivity disorder, traumatic brain injury.

Abused. These problems include: physically/emotionally abused, sexual abuse (victim), neglected.

Delinquency. These problems were: delinquency, acting-out, truancy, and aggressive behavior, and sexual abuse (perpetrator).

Health. These problems include: physical disability, visual/hearing impaired, chronic health problem, and pregnancy.

Substance abuse. Substance abuse problems.

Emotional disturbance. Emotional disturbance included youth with SED, and those who were depressed or suicidal.

Statistical Analysis

Descriptive and bivariate analyses were conducted in order to display characteristics such as age, gender, presenting problem, referral source, prior out-of-home placements and living arrangements of youth who receive services under the CSA. Univariate models were developed to compute crude odd ratios. Multiple logistic regression and multiple regression procedures were also employed.

Research Questions

Five research questions are addressed in this study. The following section states each question and provides a description of the statistical analysis.

Question 1. Are African-American youth more likely than Caucasian youth to have referrals to CSA from formal sources?

In order to determine if African-American youth were more likely than Caucasian youth to be referred to mental health services by a formal referral or an external agency, logistic regression models were developed. To address this issue, the outcome variable, referral source, was coded as one (1) for an informal referral and zero (0) for a formal referral. Beta coefficients were converted to prevalence odd ratios and were interpreted as the expected prevalence odd ratio of an informal referral. A prevalence odd ratio greater than 1 indicates that a variable increases the odds of an informal referral, and a ratio less than 1 decreases the odds of an informal referral. The logistic regression procedure was employed from the regression function in the Statistical Package Social Science (SPSS) Version 7.5 (1997).

The model building strategy outlined by Hosmer and Lemeshow (1989) was employed in this study. The variable selection process began with a univariate analysis of each variable and the outcome variable using the chi square test. Variables were entered into the model with a univariate test p-value of < 0.25 (Hosmer & Lemeshow, 1989). In addition, variables with associations suggested in the literature were included in the model. Variables were entered into the model using the "enter" method. The importance of each variable in the model was verified using the p-value and each estimated coefficient from the univariate model. Any variables which did not contribute to the model based on these criteria were eliminated and a new model was developed. Models were compared using the log likelihood test. The fit of the new model was assessed using the Hosmer and Lemeshow Goodness of Fit Test. All two-way interactions were entered in the model. Interactions and variables with insignificant p-values were not included in subsequent models.

Question 2. Do African-American and Caucasian youth differ in the type of agency likely to refer them to CSA?

In order to determine if African-American youth differ from Caucasian youth in the type of agency making referrals to mental health services, multiple logistic regression was employed. Three sets of logistic regression models were developed. The sets of regressions pertained to the category of external (formal) referral (health, school, social). Ethnicity, age, gender, abuse, cognitive/neurobehavioral, delinquency, emotional disturbance, health and substance abuse problems were entered into each logistic regression model using

the "enter" method. The model building strategy discussed earlier was also applied for this research question.

Question 3. Are African-American youth more likely than Caucasian youth to have out-of-home placements prior to CSA enrollment?

To address this research question the outcome variable, out-of-home placement, was coded as (1) yes and (0) no. Univariate analyses were conducted with the following variables: abused, cognitive, delinquency, emotion, health, substance abuse, age, gender, ethnicity, and referral source. The model building strategy outlined previously was employed for this logistic model.

Question 4. Are African-American youth more likely to have residential placements while in CSA than Caucasian youth?

To address this research question the outcome variable, residential placement, was coded as (1) yes and (0) no. Univariate analyses were conducted with the following variables: abused, cognitive, delinquency, emotion, health, substance abuse, age, gender, ethnicity, prior out-of-home placement, and referral source. The model building strategy outlined previously was employed for this logistic model.

Question 5. Do African-American and Caucasian youth differ in the length of services (LOS) in CSA?

Bivariate relationships were examined between ethnicity, gender, age, presenting problems, referral source, residential placement, and length of service using t-tests. Variables with p-values < 0.25 were entered into a multiple regression model.

Chapter IV

PRESENTATION AND ANALYSIS OF DATA

This study examined patterns of referrals, placement and length of service for African-American and Caucasian youth with serious emotional and/or behavioral problems who received services through the Comprehensive Services Act (CSA) in Virginia. Findings from the statistical analyses are presented in this chapter. Descriptive findings are provided first, followed by bivariate and multivariate findings. The characteristics of the sample are presented, followed by the presentation of results. Results are grouped according to the specific research question addressed. The research questions are as follows: (1) Are African-American youth more likely to have formal referrals to CSA than Caucasian youth? (2) Do African-American youth and Caucasian youth differ in the type of agency likely to refer them? (3) Are African-American youth more likely than Caucasian youth to have out-of-home placements prior to CSA enrollment? (4) Are African-American youth more likely to have residential placements while in CSA than Caucasian youth? (5) Do African-American and Caucasian youth differ in the length of service in CSA? An alpha level of .05 was used to determine statistical significance for all tests.

Sample Characteristics

The characteristics of the 2,883 youth included in the study are illustrated in Table II. Ages ranged from 10 to 19 years in the sample with a mean age of 14.2 years (S.D. 2.11). Males constituted 60% of the sample. Fifty-nine percent of the youth were Caucasian while 41% were African-American. There were similar

Table II

Characteristics of Study Sample by Ethnicity

	African-American (%)	Caucasian (%)	Total (%)
Gender			
Male	62	60	61
Female	28	40	40
Age			
Younger	48	50	49
Older	52	50	51
Prior out-home			
Yes	54	48	50
No	47	53	50
Residential Placement			
Yes	42	40	41
No	60	60	50

gender and age proportions among ethnic groups. The majority (53%) of the males in the samples were older (15-19 years) while the majority (52%) of females in the sample were younger (10-14 years). Half of the youth in the study had been placed out-of-home in the 12 months prior to CSA enrollment. A greater proportion of African-Americans (54%) had been placed out-of-home compared to 48% of their Caucasian counterparts. Forty-one percent of the sample had residential placements while receiving services through CSA. As illustrated in Table III, the majority of the youth were living with their parents at the time of CSA enrollment. Ten percent of the youth were in foster care at the time of

Table III

Type of Living Arrangement at CSA Enrollment

	African-American % (n)	Caucasian % (n)	Total % (n)
Own/home independent	2% (28)	2% (26)	2% (64)
Parent's home	46% (547)	55% (922)	51% (1469)
Relative's home	9% (110)	4% (62)	6% (172)
Emergency shelter	2% (22)	2% (27)	2% (49)
Substance abuse	0.2% (2)	0.4% (7)	0.3% (9)
Psychiatric hospital	2% (29)	3% (53)	3% (82)
None/homeless	0.2% (2)	0.2% (4)	0.2% (6)
Regular foster care	12% (144)	9% (157)	10% (301)
Therapeutic foster care	5% (56)	6% (105)	6% (161)
Detention facility	4% (47)	4% (62)	4% (109)
Learning center	0.8% (10)	0.5% (9)	0.7% (19)
Residential (<=12 beds)	2% (26)	2% (33)	2% (59)
Residential (>=13 beds)	6% (73)	8% (136)	7% (209)
Other	2% (27)	3% (42)	2% (69)
Not listed	6% (70)	2% (35)	4% (105)
Total	100% (1690)	100% (1193)	100% (2883)

enrollment. A higher proportion of African-Americans (12%) were in foster care than Caucasians (9%).

The most frequent presenting problems in the sample are shown in Table IV. These problems were delinquency (75%), cognitive/neurobehavioral (50%), abuse (34%), and emotional disturbance (35%). The prevalence of substance abuse and health problems was 15%, and 8% respectively. The prevalence of delinquency,

Table IV

Prevalence of Presenting Problems in Study Sample

	Prevalence (%)	N
Abused	35%	1003
Cognitive	51%	1461
Delinquency	75%	2156
Emotional Disturbance	35%	1020
Health	8%	224
Substance Abuse	15%	434

cognitive/neurobehavioral and abuse problems among African-Americans and Caucasians was similar. However, Caucasians had a higher prevalence of substance abuse problems and emotional disturbance problems than minorities ($p < .001$). As presented in Table V, males and females had a different prevalence of presenting problems for physical/sexual abuse, cognitive/neurobehavioral, health and substance abuse problems. Being female was associated with having more health problems and being abused. On the other hand, being male was associated with more cognitive/neurobehavioral, substance abuse and emotional disturbance problems ($p < .05$). Males and females had a similar prevalence of delinquency and substance abuse problems ($p > .05$). Being older was associated with having a higher prevalence of abuse problems while younger youth had a higher prevalence of cognitive/neurobehavioral, delinquency, health and substance abuse problems ($p < .001$). There were no age differences in prevalence for cognitive/neurobehavioral problems ($p > .05$).

Table V

Prevalence of Presenting Problem by Ethnicity, Gender, and Age

	Ethnicity		Gender		Age	
Presenting Problem	African-American	Caucasian	Male	Female	Younger	Older
Abuse	34.8%	34.8%	30%	43%**	31%	39%*
Cognitive	49%	52%	56%	43%	52%**	50%
Delinquency	74%	76%	76%	73%	80%	70%
Emotional	31%*	40%**	40%*	30%	31%	40%
Health	9%	7%	5%	12%**	10%**	6%
Substance Abuse	12%	18%	16%	13%	21%	9%

*< .05 **< .001 ***< .0001

The majority of youth entered the system from a formal referral source. More than half of the youth (70%) were referred to CSA from a social agency and 30% were from schools. Few referrals were from informal and health sources (4%, 7% respectively). Both groups had less informal and health referrals and more social and school referrals. However, African-American youth had a lower proportion of informal referrals and a higher proportion of social referrals to CSA than Caucasians. In contrast, Caucasians had a greater proportion of referrals from schools than African-Americans. Gender was associated with the type of referrals to services ($p < .001$) as indicated in Table VII. More females (74%) were referred to services by social agencies than males, while males had a higher percentage of referrals (32%) from schools.

Table VI

Distribution of Type of Referrals to CSA

Type of Referral	Number (n)	Percent (%)
Informal	104	4
Health	188	7
School	805	30
Social	1786	70
Total	2883	100

Table VII

Type of Referral by Ethnicity and Gender

Type of Referral	Ethnicity (%)		Gender (%)	
	Caucasian	African-American	Male	Female
Informal	4	2	4	4
Health	6	7	6	7
Social	59	66	58	68
School	31	24	32	21

Type of Referral Source and Presenting Problems

Significant associations were found between referral source and the following presenting problems: abuse, cognitive/neurobehavioral, delinquency, and substance abuse ($p < .001$). More than 80% of persons who had abuse problems were referred to CSA by a social agency. Youth with cognitive/neurobehavioral problems were referred to services primarily by social agencies (55%) and schools

(33%). Sixty-two percent (67%) of youth with delinquency problems were referred to CSA by a social source. Similarly, 68% of youth with substance abuse problems were referred to service by a social service agency. There was no significant difference in referral source for youth with and without health problems (p>.05).

Table VIII

Prevalence of Presenting Problem by Referral Source

	Informal	School	Social	Health
Abused*	3%	10%	80%	7%
Cognitive*	5%	33%	55%	8%
Delinquency*	4%	27%	62%	7%
Emotional Disturbance	5%	24%	49%	12%
Health	4%	30%	57%	10%
Substance Abuse*	4%	21%	68%	6%

*p< .05 **p< .01 ***p< .001

Research Questions

The following section presents findings for each of the five research questions in the study. Bivariate and multivariate results are provided.

Question 1. Are African-American youth more likely than Caucasian youth to have referrals from formal sources?

Informal Referrals

Bivariate and Crude Odds Ratios for Informal Referrals

Table IX displays the crude odds ratio and chi-square p-value for

associations of study variables by type of referral source. Variables which were found to be significantly associated with informal referrals were age, ethnicity, delinquency, emotional disturbance and cognitive/neurobehavioral problems. Specifically, younger youth were 1.64 times (CI: 1.10 - 2.44) more likely to have informal referrals compared to older youth. African-Americans were less likely to have informal referrals than Caucasians. Youth with cognitive/neurobehavioral and delinquency problems were both more likely to have informal referrals than youth without these problems ($p < .01$).

Multiple Logistic Regression Model for Informal Referrals

The variables in the final logistic regression model included ethnicity, cognitive and delinquency problems. African-Americans were 0.656 times less likely than Caucasians to have informal referrals to services. Youth with delinquency problems were 2.55 times (CI: 1.34 - 4.84) as likely as youth without these problems to have informal referrals. Youth with cognitive problems were 1.61 (CI: 1.06 - 2.45) times as likely as youth without these problems to have informal referrals to services.

Question 2. Do African-American and Caucasian youth differ in the type of agency likely to refer them to CSA?

In order to assess whether minorities and Caucasians differ in the type of referral to CSA, three logistic regression models were developed for social, school and health referral sources. Only youth with formal referrals were included in these models. Variables included in the regression model were: ethnicity, age, gender and presenting problem (abuse, delinquency, health, cognitive/

Table IX

Crude Odds Ratios and 95% Confidence Intervals Associated with Informal Referrals

Characteristic	OR (95% CI)	p
Youth's Age		0.009
10-14	1.64 (1.10-2.4)	
Ethnic Background		0.021
African-American	0.639 (.4206-.9720)	
Gender		0.410
Female	1.06 (.718-1.58)	
Abuse	0.935 (.6185-1.41)	0.419
Cognitive	1.90 (1.26-2.87)	0.001
Delinquency	2.96 (1.57-5.57)	0.000
Emotional	1.44 (0.974-2.14)	0.067
Health Problems	0.978 (0.469-2.03)	0.569
Substance Abuse	1.34 (0.816-2.21)	0.152

neurobehavioral, emotional and substance abuse).

Social Referrals

Several variables were found to be significantly associated with referrals from social agencies as noted in Table XI. Younger youth were 1.27 (CI: 1.09-1.45) times more likely to be referred from social agencies than older youth. African-Americans were 1.36 (CI: 1.17-1.59) times more likely to have referrals from social agencies than Caucasians. In addition, females were 1.57 (CI: 1.34 - 1.84) more likely than males to have social referrals. The presenting problems significantly associated with social agency referrals were: abuse (OR: 3.73; CI:

Table X

Adjusted Odds Ratio and 95% Confidence Interval for Variables Associated with Informal Referrals to CSA in Logistic Regression Analysis

Variable	Adjusted Odds Ratio (95% CI)
Race	
African-American	0.656 (0.390-.898) *
Problem	
Cognitive/Neurobehavioral	1.61 (1.06-2.45) *
Problem	
Delinquency	2.55 (1.34-4.84) **

*< .05 **< .01 ***< .001

3.11-4.47), emotional disturbance (OR: 0.431; CI: 0.367-0.505), and substance abuse (OR: 1.38; CI: 1.11-1.72).

Multiple Logistic Regression for Social Referrals. Variables that significantly contributed to the explanatory power of the model and were included in the final logistic regression model were ethnicity, gender, age, abuse, substance abuse, cognitive, emotional and health. Results of the logistic regression model indicate African-Americans were 1.37 (CI: 1.16-1.62) time more likely than Caucasians to have referrals from social agencies. Youth with abuse problems were 4.2 (CI: 3.51-5.15) times more likely than youth without abuse problems to be referred by a social agency. Youth with substance abuse problems were 1.54 (CI: 1.24-1.95) times more likely than youth without substance abuse problems to be referred by a social agency. Emotional and cognitive problems did not

Table XI

Crude Odds Ratios and 95% Confidence Intervals Associated with Social Referrals

Characteristic	OR (95% CI)	p
Youth's Age		
10-14	1.27 (1.09-1.45)	0.001
Ethnic Background		
African-American	1.36 (1.17-1.59)	0.001
Gender		
Female	1.57 (1.34-1.84)	0.000
Abuse	3.73 (3.11-4.47)	0.000
Cognitive	0.529 (0.454-0.616)	0.000
Delinquency	.972 (0.817-1.15)	0.748
Emotional	0.431 (0.367-0.505)	0.000
Health Problems	0.789 (0.599-1.03)	0.092
Substance Abuse	1.38 (1.11-1.72)	0.004

increase the likelihood of a social agency referral.

School Referrals

Bivariate Results. Significant variables in the univariate models were age, gender, abuse, cognitive, emotion, and substance abuse ($p < .01$). Younger youth were less likely (OR: 0.748; CI: 0.635-0.881) than older youth to have school referrals. Females were less likely to have school referrals than males (OR: 0.569; CI: 0.478-0.676). In addition, African-Americans were 0.727 times less likely than Caucasians to have school referrals to CSA. Youth who were abused were 1.80 times (CI: 0.143-2.26) more likely than non-abused youth to have referrals from

Table XII

Adjusted Odds Ratios and 95% Confidence Intervals for Variables Associated with Social Agency Referrals

Variable	Odds Ratio 95% Confidence Interval
Ethnic Background	
African-American	1.37 (1.16-1.62)***
Abuse	
Yes	4.25 (3.51-5.15)***
Age	
Younger	1.29 (1.09-1.46)**
Substance Abuse	
Yes	1.54 (1.21-1.96)***
Gender	
Female	1.23 (1.03-1.47)*
Cognitive	
Yes	0.543 (.457-0.646)***
Emotional	
Yes	0.423 (0.360-0.509)***

*< .05 **< .01 ***< .001

schools. Youth with cognitive problems were more likely than youth without these problems to have referrals from schools.

Multiple Logistic Regression Model for School Referrals. The main effects in the model included age and substance abuse. The interaction effects in the model were: abuse by ethnicity, cognitive by ethnicity, emotional disturbance by ethnicity, delinquency by gender, abuse by delinquency. Youth with substance

Table XIII

Crude Odds Ratios and 95% Confidence Intervals Associated with School Referrals

Characteristic	OR (95% CI)	p
Youth's Age		
10-14	0.748 (0.635-0.881)	0.001
Ethnic Background		
African-American	0.727 (0.615-.0.881)	0.000
Gender		
Female	0.569 (0.478-0.676)	0.000
Abuse	1.80 (0.143-2.26)	0.000
Cognitive	1.64 (1.39-1.93	0.000
Delinquency	0.972 (0.8178-1.15)	0.748
Emotional	0.431 (0.367-0.505)	0.000
Health Problems	1.11 (0.824-1.50)	0.489
Substance Abuse	0.655 (0.512-0.837)	0.001

abuse problems were 0.622 times (CI: 0.477-0.814) less likely than youth with substance abuse problems to have school referrals. Younger youth were 0.742 times less likely (CI: 0.618-0.891) to have school referrals than older youth.

The effect of race was found to depend on the youth's status in the categories of abuse, cognitive/neurobehavioral and emotional disturbance problems. As a result, odds ratios were computed for the following eight groups: (Group 1) youth with abuse, cognitive and emotional problems; (Group 2) youth with abuse problems, and cognitive problems and without emotional disturbance problems (Group 3) youth with abuse problems and with emotional disturbance

Table XIV

Adjusted Odds Ratios and 95% Confidence Intervals for School Referrals

Variables	Adjusted Odds Ratio 95% Confidence Interval
Age	
10-14	0.741 (0.618-0.891)**
Substance Abuse	
Yes	0.622 (0.477-0.814)***
Race by Abuse, Cognitive & Emotional	
Group 1(Abuse, Cognitive, Emotional)	2.28 (1.41-3.681)*
Group 2(Abuse & Cognitive)	1.16 (0.713-1.91)
Group 3(Abuse & Emotional)	1.24 (0.729-2.13)
Group 4(Cognitive & Emotional)	1.23 (0.876-1.73)
Group 5(Abuse)	0.638 (0.337-1.34)
Group 6(Cognitive)	0.630 (0.317-1.25)
Group 7(Emotional)	0.674 (0.132-3.07)
Group 8(None)	0.345 (0.252-0.471)*
Gender *Delinquency	
Group 1 (D=1)	0.908 (0.573-1.43)
Group 2 (D=0)	0.349 (0.232-0.524)*

* p< .05 ** p< .01 *** p< .001

problems (Group 4) youth with cognitive and emotional disturbance problems (Group 5) youth with abuse problems, without cognitive problems, without emotional problems, (Group 6) youth with cognitive problems, (Group 7) youth without abuse problems, without cognitive problems and with emotional problems; and (Group 8) youth without abuse problems, without cognitive problems and

without emotional disturbance problems. Among youth with all three presenting problems (Group 1), African-Americans were 2.28 times more likely than Caucasian youth to have referrals from schools. Among youth with abuse and cognitive problems (Group 2), African-Americans were 1.16 times more likely than Caucasian to have referrals from schools. Among youth with abuse and emotional problems (Group 3), African-American youth were 1.24 times more likely than Caucasian youth to have referrals from schools. Among youth with cognitive and emotional problems (Group 4), African-American youth were 1.23 times more likely than Caucasians to have referrals from schools. Among youth in Group 5, African-Americans were 0.6376 less likely to have referrals from schools than Caucasians. Among youth with cognitive problems (Group 6), African-American youth were .631 times less likely than Caucasian to have referrals from schools. Among youth with emotional problems (Group 7), African-American youth were .6739 times less likely than Caucasian youth to have referrals from schools. Among youth without any of the three problems (Group 8), African-American youth were .345 times less likely than Caucasian to have referrals from schools.

The effect of gender on school referrals was found to depend on whether the youth was delinquent. Therefore odds ratios were computed for females who were delinquent compared to males who were delinquent and females who were not delinquent compared to males who were not delinquent. Among youth who were delinquent, females were 0.908 times less likely than males to have referrals from schools. Among youth who were not delinquent, females were 0.349 times

Table XV

Crude Odds Ratios and 95% Confidence Intervals for Health Referrals to CSA

Characteristic	OR (95% CI)	p
Age		
Younger	0.769 (0.57-1.04)	0.084
Ethnic Background		
African-American	1.077 (0.799-1.45)	0.624
Gender		
Female	1.044 (0.773-1.41)	0.775
Abuse	1.02 (0.745-1.38)	0.925
Cognitive	1.61 (1.19-2.19)	0.002
Delinquency	0.982 (0.699-1.37)	0.918
Emotional	3.35 (2.46-4.55)	.000
Health Problems	1.64 (1.02-2.60)	0.039
Substance Abuse	0.942 (0.618-1.43)	0.784

less likely than males to have referrals from schools.

Health Referrals

Bivariate Results. Youth with cognitive problems were 1.61 times (CI: 1.19-2.19) more likely to have referrals from health sources. In addition youth who had health problems were 1.64 times (CI: 1.02-2.60) more likely to have referrals from health sources. Youth with emotional problems were 3.35 times (CI: 2.46-4.55) more likely than youth without emotional problems to have referrals from health sources. Age, ethnicity, gender or substance abuse problems were not associated with health referrals.

Table XVI

Odds Ratios and 95% Confidence Interval for Health Referrals

Variable	Adjusted Odds Ratio 95% Confidence Interval
Health	1.73 (1.07-2.78)*
Yes	
Emotion	3.38 (2.49-4.59)***
Yes	

*p< .05, ***p< .001

Multiple Logistic Regression Model for Health Referrals. The variable in the final model included health and emotion. Youth with health problems were 1.73 (CI: 1.07-2.78) times more likely than youth without health problems to have health referrals. Youth with emotional problems were 3.38 times (CI: 2.49-4.59) more likely than youth without emotional problems to have health referrals.

Question 3. Are African-American youth more likely than Caucasian youth to have out-of-home placements prior to CSA enrollment?

Out-of-Home Placements

Bivariate Results. Variables that were significant in the univariate analyses were ethnicity, gender, age delinquency, abuse and health. African-Americans were 1.27 (CI: 1.09-1.47) more likely than Caucasians to have out-of-home placement prior to CSA enrollment. Females were found be 1.23 times (CI: 1.05-1.45) more likely than males to have out-of-home placements. In addition, youth who were abused were 2.69 times more likely than youth who were not abused to have out-of-home placements. Youth with health problems were 1.64

Table XVII

Crude Odds Ratios and 95% Confidence Interval for Prior Out-of-Home Placements in CSA

Characteristic	% Out-of-Home Placements	OR (95% CI)	p
Age			
10-14	54	1.36 (1.17-1.58)	.000
15-19	46		
Ethnic Background			
African-American	54	1.27 (1.09-1.47)	.001
Caucasian	48		
Gender			
Female	53	1.23 (1.05-1.45)	.004
Male	21		
Abuse	66	2.69 (2.29-3.16)	.000
No Abuse	41		
Cognitive	50	0.959 (0.827-1.11)	.306
No Cognitive	50		
Delinquency	49	0.918 (0.777-1.09)	0.336
No Delinquency	52		
Emotional	52	1.15 (0.988-1.34)	.070
No Emotional	49		
Health Problems	61	1.64 (1.24-2.17)	.000
No Health Problems	49		
Substance Abuse	59	1.56 (1.27-1.93)	.000
No Substance Abuse	48		

times (1.24 - 2.17) more likely to have out-of-home placements while youth with substance abuse problems were 1.56 (1.27 - 1.93) times more likely to have out-of home placement than youth without substance abuse problems.

Multiple Logistic Regression Results

The final model included the following variables: ethnicity, abuse, age, race, health and substance abuse as illustrated in Table XVIII. African-Americans were 1.31 (CI: 1.13-1.54) times more likely than Caucasians to have out-of-home placements prior to CSA enrollment. The logistic regression model also indicated that youth who were abused were 2.81 times more likely than youth who had not been abused to have out-of-home placements prior to CSA enrollment. In addition, younger youth were 1.4 (CI: 1.19-1.64) times more likely than older youth to have out-of-home placements prior to CSA enrollment. Youth who had health and substance abuse problems were more likely than youth without these problems to have out-of-home placements prior to CSA enrollment (OR: 1.5; CI: 1.18-2.11; OR: 1.55; CI: 1.23-1.93 respectively).

Question 4. Are African-American youth more likely than Caucasian youth to have residential placements in CSA?

Residential Placements

Bivariate and Crude Odd Ratio Results. Forty percent of youth in the sample had a residential placement. More females (40.1%) used residential services than males ($p < .001$). Table XIX displays sample characteristics, crude odds ratios and p-values associated with residential placement. There is a significant association between gender and residential placements, abuse and

Table XVIII

Odds Ratios and 95% Confidence Interval for Out-of-Home Placements in CSA

Variable	OR (95% CI)
Ethnicity	
African-American	1.32 (1.12-1.54)***
Abuse	
Yes	2.81 (2.39-3.30)***
Health	
Yes	1.58 (1.18-2.12)**
Substance Abuse	
Yes	1.55 (1.25-1.93)***

**p< .01 ***p< .001

residential placement, cognitive/neurobehavioral problems and residential placement, and emotional problems and residential placement. Youth with cognitive/neurobehavioral, delinquency and emotional problems were less likely to use residential services than youth without these problems. Youth with abuse problems were 3.33 (CI: 2.84 - 3.91) times more likely than youth without abuse problems to have residential placements. Females were 1.33 times (CI: 1.14 - 1.55) more likely to have residential placements than males.

Logistic Regression Model for Residential Service Placement

The final model included abuse, prior out of home placement, delinquency by ethnicity interaction, cognitive by health interaction, and cognitive by emotion interaction. Youth with abuse problems were 2.84 (CI: 2.37 - 3.39) times more likely than youth without abuse problems to have residential placements. Youth

Table XIX

Characteristics of Youth in CSA, Percent with Residential Placements, Odds Ratios (OR), and 95% Confidence Intervals

Characteristic	Residential Placements %	OR (95% CI)	p
Referral Type			0.312
Informal	45	1.22 (0.827-1.81)	
Formal	40		
Age			0.842
10-14	41	1.01 (0.877-1.17)	
15-19	41		
Ethnic Background			.0291
African-American	42	1.08 (.932-1.26)	
Caucasian	41		
Gender			0.000
Female	45	1.33 (1.14-1.55)	
Male	38		
Abuse	60	3.33 (2.84-3.91)	0.000
No Abuse	31		
Cognitive	35	0.612 (0.527-0.711)	0.000
No Cognitive	47		
Delinquent	37	0.563 (0.475-0.667)	0.001
Not Delinquent	51		
Emotional	37	1.15 (0.988-1.34)	.070
No Emotional	43		
Health Problems	46	1.64 (1.24-2.17)	.000
No Health Problems	41		
Substance Abuse	40	0.949 (0.770-1.16)	.623
No Substance Abuse	41		

Characteristic	Residential Placements %	OR (95% CI)	p
Out-of-Home Placement	61	6.03 (5.10-7.14)	0.000
Not Out-of-Home Placement	30		

with previous out-of-home placements were 5.6 (CI: 4.72 - 6.77) times more likely than youth without prior out-of home placements to have residential placements. The effect of ethnicity regarding residential placements was found to depend on whether or not the youth was delinquent. Therefore, odds ratios were computed separately for the two groups according to race: (1) youth with delinquency problems and (2) youth without delinquency problems. Among youth who were delinquent, African-Americans were 0.755 (CI: 0.615 - 0.928) times less likely to have a residential placement. A trend was noted among youth who were not delinquent. Among these youth, African-Americans were 1.25 (CI: 0.088 - 1.79) times more likely to have residential placements. However this was not statistically significant.

The effect of cognitive problems related to residential placement was found to depend on whether the youth had an emotional disturbance. The interaction effect provided odds ratios regarding the effect of a combination of problems. As a result, it was necessary to compute for cognitive problems for youth with and without health and emotional disturbance problems. This resulted in the following four groups of youth with cognitive problems: Group (1) youth with health and emotional problems; Group (2) youth with health problems and

without emotional problems; Group (3) youth without health problems and with emotion problems; Group (4) youth without health problems and youth emotional problems. Interaction odds ratios are presented in Table XX. Findings from the interaction of cognitive with health and emotional problems indicated that having health and emotional problems was found to increase the risk of residential placement for youth with cognitive problems. On the other hand, as the number of problems decreased, the risk of residential placement for youth with cognitive/ neurobehavioral problems decreased. Groups with significant odds ratios for youth with cognitive problems were youth with both health and emotional problems and youth with cognitive problems who did not have health or emotional problems. Among youth who had health and emotional problems (Group 1) youth with cognitive problems were 2.58 times more likely than those without cognitive problems to have residential placements. Among youth who had health problems but did not have emotional disturbance problems (Group 2), those with cognitive problems were 1.23 times more likely than youth without cognitive problems to have residential placements. Among youth without health and with emotional disturbance problems (Group 3), youth with cognitive problems were 0.987 less likely than youth without cognitive problems to have residential placements. Among youth without health problems and without emotional problems (Group 4), youth with cognitive problems were 0.471 less likely to have residential placements.

Question 5. Do African-American and Caucasian youth differ in the length of services (LOS) in CSA?

Table XX

Adjusted Odds Ratios and 95% Confidence Intervals for Variables Associated with Residential Service Use

Variable	Adjusted Odds Ratio (95% CI)
Problem	
Abuse **	2.84 (2.37-3.39)
Out-of-Home Placement	
Yes	5.6 (4.72-6.77)
Race by Delinquency	
Group 1 *	.755 (0.615-.928)*
Group 2	1.25 (.088-1.79)
Cognitive by Health & Emotion	
Group 1 (Cognitive, Health, & Emotion)	2.58 (1.17-5.69)*
Group 2 (Cognitive & Health)	1.23 (.647-2.35)
Group 3 (Cognitive & Emotion)	0.986 (0.729-1.33)
Group 4 (Cognitive)	0.471 (.373-.594)*

*p< .05 **p< .01

Length of Service (LOS)

Bivariate Analyses for LOS. Caucasians' average length of service, 353.6 days, was longer than African-American youth (295.8 days). This difference was statistically significant (p=0.008). There was also a significant difference in the average length of service for males and females. Females' average length of service in CSA was 355.6 days and males' average length of service was 310.3 days. In addition, youth who had residential placements had a significantly longer length of stay than youth who did not have residential placements. There was not

a significant difference in length of service for any of the presenting problems (cognitive, delinquency, emotional, health or substance abuse) or informal and formal referrals.

Table XXI

Sample Characteristics and Average Length of Service in CSA

	Mean LOS (days)	SD	p-value
Ethnic Background			
African-American	295.77	222.49	0.008
Caucasian	353.58	201.99	
Gender			
Male	310.32	214.08	0.032
Female	355.55	215.44	
Age			
Younger	336.15	232.45	0.212
Older	316.45	204.22	
Abused			
Yes	342.35	237.4	0.205
No	321.48	203.5	
Cognitive			
Yes	345.8	229.2	0.056
No	307.7	186.4	
Delinquent			
Yes	325.2	211.2	0.297
No	340.9	231.8	

	Mean LOS (days)	SD	p-value
Emotional			
Yes	353.3	201.8	0.091
No	318.2	220.4	
Health			
Yes	381.4	211.8	0.083
No	323.3	215.4	
Substance Abuse			
Yes	352.9	228.9	0.201
No	324.3	213.2	
Residential			
Yes	380.6	235.0	.000
No	298.9	198.0	
Referral Source			
Informal	380.7	213.0	0.207
Formal	326.6	283.3	

Multiple Regression Model for LOS. Multiple regression was employed to determine if ethnicity would remain a significant predictor in LOS controlling for other variables in the model. Variables with p-values < 0.25 in the bivariate analyses were entered in the regression model. Variables in the model included, ethnicity, gender, age, abuse, cognitive, delinquency, health, substance abuse and referral source. After the first model was executed, variables with insignificant p-values (>.05) were removed from the model. The final model included ethnicity and residential placement. Although these variables were significant predictors of LOS, the R square value was very low. This indicated the study variables only account for 5% of the variance in length of service.

Chapter V

DISCUSSION, CONCLUSION, SUMMARY AND RECOMMENDATIONS

The purpose of this secondary analysis was to examine racial differences in referrals, placement and length of service in mental health services. The study included a sample of 2,883 youth aged 10 to 19 years old with serious emotional and/or behavioral problems who received services through the Comprehensive Services Act in Virginia. These analyses suggest the existence of racial differences in referrals to mental health services, prior out-of-home placements and length of service. Along with identifying racial differences and similarities in service use, this study found that being abused was associated with referrals, out-of-home placements and residential placements in CSA. The remaining sections of this chapter highlight results as they pertain to the theoretical framework and the primary research questions addressed in this study.

Labeling theory, also referred to as societal reaction theory, was used as the framework for this study. The labeling perspective centers on societal reaction to deviance. Based on this theory the following hypotheses were employed to guide the study:

H1 African-American youth would be more likely to have formal referrals to CSA than Caucasian youth.

H2 African-American youth would be more likely to have out-of-home placements prior to CSA enrollment than Caucasian youth.

H3 African-American and Caucasian youth would differ in type of school, health and social agency referrals to CSA.

H4 African-Americans would be more likely than Caucasians to have residential placements while receiving services through CSA.

H5 African-Americans would have a shorter length of service in CSA than Caucasians.

Four of the five hypotheses were validated. The hypothesis that was not supported was the expectation African-Americans would be more likely to have residential placements while receiving services in CSA. The effect of ethnicity on residential placement was complex in that it depended on whether the youth was delinquent. A trend was noted, among youth who were delinquent, African-Americans were more likely to have residential placements. However, this was not statistically significant. Referrals to CSA were classified as either informal or formal. In this study, informal referrals are defined as referrals from family, friends, and self-referrals. Agency referrals were defined as formal referrals. Ethnicity was found to have a significant effect on whether youth had formal or informal referrals, that is African-American youth were 1.5 times more likely than Caucasians to have formal referrals to CSA controlling for presenting problems, gender and age. This finding is in agreement with Takeuchi et al. (1993) who found African-Americans to be 1.48 times more likely to have formal referrals to mental health services than Caucasians. However, when Takeuchi and colleagues (Takeuchi et al., 1993) controlled for the effects of age and poverty status, the differences between African-Americans and Caucasians were no longer significant. As stated previously, significant differences remained in this study when controlling for presenting problem, age and gender. However, due to the nature

of the data available in this study, there were no indicators of poverty or socioeconomic status in the data set and these findings may reflect that factor.

It is expected poverty status or another SES variable would help explain racial differences in referral patterns. This is primarily because poverty status has been found to be a strong predictor of formal referrals (Briones, Heller, Chalfant, Roberts, Aguirre & Farr, 1990; Costello & Janiszewski, 1990). Yet it is difficult to assess whether the presence of these variables in this study would explain all of the racial differences. The available research is not definitive. For example, Takeuchi and colleagues found poverty status explained racial differences in coercive or formal referrals to mental health services. On the other hand, when Rosenfield (1982) controlled for the effects of poverty, racial differences were not explained by poverty status. Studies which control for SES are needed when assessing referrals to mental health care.

In addition to supporting the labeling perspective, the finding that African-American youth are less likely to have informal referrals to CSA is consistent with findings in the literature which suggest African-Americans are less likely than Caucasians to initiate treatment from mental health service providers (Broman, 1987; Neighbors, 1985; Neighbors & Jackson, 1984). One explanation offered for African-Americans' reluctance to initiate treatment is that they use informal networks to cope with mental health problems (Neighbors & Jackson, 1996). Others have reported that African-Americans have a greater fear of institutionalization, associate a greater stigma with mental health service use than Caucasians and have less faith in the benefits of psychotherapy than Caucasians

(Snowden & Cheung, 1990; Sussman, Robin, & Earls, 1987).

Other factors significant in predicting informal referrals in the multivariate model were cognitive and delinquency problems. Youth with cognitive and delinquency problems were more likely to have informal referrals to CSA than youth without these problems. Perhaps this is because of the manner in which symptoms of these problems manifest. For example, youth with cognitive/ neurobehavioral problems such as attention deficit disorder may have symptoms that are present in both the school and home setting. As a result, parents may receive verification of the child's need for treatment. Similarly, youth with delinquency problems such as acting out would also typically present symptoms in more than one setting. Furthermore, delinquency problems often cause family disruption which parents may deem unbearable and influence them to make referrals to CSA.

Only a small percentage of referrals to CSA were from informal sources. Several factors may account for these low rates. First, many of the youth in CSA may have already been receiving services from another agency and, as a result, the agency made the referral to CSA. Furthermore, although the CSA Act states families may make referrals to CSA, some localities may encourage agencies to make referrals on behalf of the family. In doing this, the referring agency may function as a case manager for youth as well as commit funds from its agency's allocated funds pool. Agency referrals do not necessarily mean family members or significant others are not involved in the referral process. As Takeuchi and others (1993) point out, quite often negotiations are made between families and

the referring agency. Given the nature of these data, it is not possible to comment on these social processes. Additional data are necessary that would detail the social processes regarding referrals to CSA. These data, however, could be useful in future studies determining what characteristics cause families to be more or less involved in the referral process.

Significant differences were found between African-American and Caucasian youth in the type of agencies likely to refer them to treatment. For example, African-American youth were more likely to have referrals from social agencies than Caucasians. This difference remained significant when controlling for presenting problems and other demographic variables. The finding that African-Americans were 1.4 times more likely to have referrals from social agencies than Caucasians may provide additional support to the labeling perspective. According to the labeling perspective, African-American youth have more severe societal reactions for their residual deviance and therefore, they are more likely to be labeled by social agencies as needing mental health services. This finding is comparable to that of Takeuchi et al. (1993). In their study, the researchers found African-American youth to be 1.5 times more likely to have referrals from social agencies when controlling for gender, age and poverty status. An alternate explanation may be that social agencies act as referral sources for African-American families because the agency perceives that the family has difficulties seeking care (Takeuchi et al., 1993). Further, African-Americans' greater likelihood of social agency referrals may reflect African-Americans' disproportionate contact with these systems. For example, if African-Americans

have more contact with these systems, it is expected that there may be more opportunities for case finding among this subpopulation.

Other variables in the multivariate model associated with referrals from social agencies were "abuse," "cognitive," "emotion," "health," "substance abuse," "gender," and "age." The presence of abuse provided the greatest probability for social agency referrals. Youth who had been abused were over four times more likely to have referrals from social agencies than youth who had not been abused. Abuse problems seem to be unique from the other problems presented in that abused youth are generally victims of another individual's (typically adults) actions or deviance. In instances of child abuse and neglect, it is other individuals' behavior (not the victimized youths) which warrants social service and police interventions. Staff in social agencies are often trained to identify these problems and tasked to intervene by referring youth to child protective and welfare services. Therefore, it is expected that abused youth would be more likely to have involvement with social/legal agencies than unabused youth. Although factors such as age, gender, abuse, and substance abuse were significant in the multivariate model, they did not explain the racial differences in referrals from social agencies. Therefore, these factors do not weaken support for the theoretical framework.

In the univariate model, African-Americans were 0.73 times less likely than Caucasians to have referrals from schools. In a similar comparison, Takeuchi et al. (1993) found African-Americans to be 0.56 times less likely to have referrals from schools. In the study by Takeuchi and colleagues (1993), African-Americans

remained less likely (.76) to have school referrals when controlling for gender, age, and poverty status. Takeuchi and others did not specify the clinical symptomology of the youth nor interactions among diagnoses. However, the current study found significant interactions between ethnicity and abuse, cognitive and emotional problems. The effect of ethnicity on school referrals was found to depend on whether the youth had cognitive problems, emotional problems or had been abused. When all three problems were present, African-Americans were more likely to have school referrals than Caucasians. When these problems were present individually (only cognitive), African-Americans were less likely to have referrals from schools. The same was found when all three problems were absent. In general, African-Americans' odds of a school referral increased as the number of problems increased. Among youth who had abuse, cognitive and emotional problems, African-Americans were more likely to have referrals from schools. The implication of these findings is difficult to determine. One interpretation might be that the presence of multiple problems prompts teachers and others in schools to identify African-American youth as needing an intervention more than Caucasian youth with similar problems.

Overall, there were few referrals from health agencies. This may suggest these agencies are better equipped to handle the needs of youth with serious emotional and behavioral problems than schools or social agencies. On the other hand, it may also reflect the lack of awareness of CSA by certain mental health professionals, particularly private providers. Until the recent rise of Medicaid managed care, private providers traditionally served patients with private

insurance. Many private providers now treat low-income populations. As a result of this new practice, private providers may not be aware of services such as CSA that may be available through public mental health and social service systems. It may be necessary to assess whether there is a need to increase private providers' awareness of CSA, particularly since individuals enrolled in Medicaid managed care may benefit from the multiple services available through CSA.

No differences were found between African-Americans and Caucasians in health referrals to CSA. Similarly, in Takeuchi and colleagues' (1993) study of ethnic differences in referrals to mental health services, no significant differences were found in health referrals for African-Americans and Caucasians. It appears mental health agencies generally treat both groups within its systems rather than make referrals to CSA. Perhaps this is because these entities typically have more extensive in-house treatment capabilities than schools or social/legal agencies. Therefore, mental health agencies would be less likely to identify youth as needing a referral to CSA. Given that one of the goals of CSA is to provide a coordinated array of services to youth with serious emotional and behavioral problems, it is not clear whether this finding is positive or negative for youth.

The findings of this study are similar to other studies related to rates of out-of-home placements reported in the literature (Stehno, 1982; Takeuchi, et al., 1993). In this study African-Americans were 1.3 times more likely to have out-of-home placements before CSA enrollment controlling for presenting problems, age, and gender. This finding would support the labeling perspective, that African-American youth incur more severe reactions to their deviance than

their Caucasian counterparts. Other studies have reported that minorities are over-represented in virtually all types of out-of-home placements (U.S. Bureau of Juvenile Justice and Delinquency Prevention, 1983; 1987). Given this finding it is possible providers may have different reactions to African-Americans' and Caucasians' deviance. Researchers have noted minorities are often treated differently than Caucasians in the mental health system (Stehno, 1982; Blum, Harmon, Harris, Bergeisen & Resnick, 1992). As a result, minority youth often experience more restrictive interventions and encounter fewer community-based alternatives than Caucasians (Isaacs-Shockley, Cross, Barzon, Dennis & Benjamin, 1996). Researchers Isaacs-Shockley et al., (1996), Comer & Hill, (1985) and Gibbs (1988) have reported there is higher probability that African-American youth with serious emotional disturbances receive placements in the juvenile justice system while their Caucasian counterparts are more likely to be referred to treatment. One limitation of several studies is the failure to specify or control for clinical symptoms. Krisberg, Schwartz, Fishman, Eiskovits, and Guttman (1986) found African-American youth were more likely to be arrested, convicted and incarcerated for similar serious offenses than Caucasians although there were no significant differences between the youth in self-reported rates of delinquency. Yet, studies have consistently demonstrated that African-American youth are over-represented in the juvenile justice system in comparison to Caucasians. Lewis, Shanok, Cohen, Klingfeld and Frisone (1980) controlled for difference in symptomology when examining racial differences in incarceration and hospitalization of youth. The researchers compared psychiatric symptoms, violent

behaviors and medical histories of youth in the same low-income community who were either referred to a correctional school or the only state hospital psychiatric unit. The most powerful explanatory variable in the analysis, found to distinguish placement, was ethnicity rather than behaviors or psychopathology. These findings accentuate the notion that aggressive, psychiatrically-disturbed African-American youth are more likely to be incarcerated while similiarly disturbed Caucasian youth receive treatment (Lewis et al., 1980; Isaacs-Shockley et al., 1996).

Another reason cited for the different societal reactions for minority youth is the lack of culturally competent prevention and treatment strategies. This may be extremely important given that ethnicity has been posited to influence the manner in which symptoms are manifest (Gibbs & Huang, 1989). A further explanation for African-Americans' greater likelihood of out-of-home placements may be African-Americans' reluctance to seek help prevents youth from receiving necessary help until the symptoms are more severe. However, in this study significant differences remained when controlling for the type of problems.

Other explanations of African-Americans' greater likelihood of out-of-home placements may be related to circumstances associated with the families and providers. African-Americans' family situation may be or appear unstable to providers and as a result, providers deem out-of-home placements to be in the best interest of the youth and the family. Related to this is the possibility that providers may not feel the family is sufficiently able to manage the child. Additionally, given data which indicates African-Americans are more likely to

terminate treatment prematurely, providers may feel placing the youth in treatment out-of-home will ensure he/she will get the necessary services (Bui & Kim, 1992). Finally, African-Americans' greater likelihood for out-of-home placements prior to CSA enrollment may be due to the absence of accessible and appropriate community-based services in their community.

The effect of ethnicity on residential placements was found to depend on whether or not the youth was delinquent. Among youth who were delinquent, African-American youth were less likely to have residential placement in CSA. This finding would not support the labeling perspective which would have predicted African-Americans to have more residential placements than Caucasians while controlling for presenting problems and other demographic factors. However, it is not clear whether this is positive or negative for African-American youths. Given that CSA does not include data regarding placements in juvenile justice system, it is not clear whether delinquent African-American youth are being referred to that system.

The most significant predictor of residential placements was having a prior out-of-home placement. Youth with prior-out-of-home placements were 5.6 times more likely than youth without prior out-of-home placements to use residential services while in CSA. This finding would support the labeling perspective which would predict youth with formal pathways or referrals to care would encounter more severe reactions to their deviance when entering care than those with informal pathways to care. Since African-Americans were more likely to have out-of-home placements, they may also be at greater risk of residential

placements. In that how an individual gets to care has been found to influence the type of services received while in treatment, this may be a potential issue of concern (Bui & Kim, 1992).

Other significant variables which increased the likelihood of residential placements were "abused," "cognitive," "health" and "emotional" problems. The effect of cognitive problems was found to depend on whether the youth also had health and emotional problems. Youth with all three of these problems were 2.6 times more likely to have residential placements. On the other hand, youth with cognitive problems who did not have health and emotional problems were less likely than youth without cognitive problems to have residential placements. This may suggest the presence of cognitive problems alone does not increase a youth's risk of residential placements. It is the combination of problems which increase a youth's likelihood of residential placement. Finally, youth who were abused were 2.8 times more likely to have residential placements than youth who were not abused. Since these were youth who had some form of sexual or physical abuse or neglect, residential placement seemed to be more of a protective issue.

The average length of service for all youth was 328 days. African-American youth had a significantly shorter length of service (296 days) than Caucasians (354 days). This finding is in concert with Bui and Takeuchi (1992) who found African-Americans to have significantly shorter length of stay in treatment than Caucasians. This finding supported the labeling perspective, which predicted African-Americans' LOS in CSA to be shorter. None of the presenting problems were significant predictors of length of stay. Residential placement was the only

other variable that was a significant predictor of LOS. As expected, persons who had a residential placement had a significantly longer LOS than youth who did not have a residential placement. These findings suggest a need to identify other factors that influence length of service. It is likely conditions such as family structure and attitudes toward care may provide additional information regarding LOS. Additionally, it is likely factors germane to the organization or providers may provide information regarding variables that affect LOS. More information is needed in this area.

This study is limited in its ability to establish causal relationships between variables which increase the likelihood of formal, school, health and social referrals or residential placements. In addition, it is limited to the localities which submitted complete data from July 1993 until June 1996. However, a unique feature of this study is that it includes data from across four sectors, Mental Health, Education, Social Services and Juvenile Justice. This is extremely valuable in that youth with serious emotional and/or behavioral problems often receive services from several human service agencies.

Major Conclusions

Based on the findings from this study the following conclusions are offered.

African-American youth are more likely to enter the CSA system from formal referral sources and social agencies than Caucasians controlling for presenting problems, age and gender. Among youth who were delinquent, African Americans were less likely than Caucasian youth to have residential placements in CSA. Also, African-American youth were more likely to have

out-of-home placements prior to receiving services through CSA.

Ethnicity may influence the manner in which school and social agencies label youth's behavior. As a result, there is a need for increased cultural awareness among providers and parents. In turn, there may also be a need to educate parents regarding efficacy of early identification of problems as well as seeking help in early stages. Given that African-Americans are less likely to have informal referrals and significantly shorter LOS while in CSA when controlling for presenting problems, age, and gender, there seems to be a need to further address racial differences in mental health service use. Attention should be given to family characteristics and attitudes as well as the characteristics and attitudes of providers.

Problems of child abuse are prevalent among youth in CSA. Consequently, there is a great need for continued efforts in education and prevention of child abuse in Virginia. There is also a need for standardized criteria for placement in order to address the appropriateness of residential placements by CSA in the future.

Implications for the Future

Based on the conclusions cited above, it is suggested that policy makers and providers recognize the fact that African-American and Caucasian youth may have different paths or referrals to treatment and that these differences may affect the type of services, length of service and treatment outcomes for youth. In order to address these potential differences the following recommendations are provided. Additional funding must be provided in order to assess the treatment outcomes

and appropriateness of service placements for all youth in CSA. Standard criteria or guidelines for localities are necessary in order to address appropriateness and parity of residential placements in CSA.

The cultural competency of service providers as well as the service system should continue to be assessed and a culturally sensitive approach incorporated into policy and service delivery. This approach should encourage service providers to have some knowledge of the youths' cultural background, attitudes, norms and how socioeconomic status affects the youths' and families' lifestyles.

Also, interventions should be developed to address cultural differences in perceived barriers or stigma associated with mental health service use. Lay helpers may be useful in this area.

The results of this study are in concert with the few studies which have examined referrals of youth to mental health services. This study has added to the empirical literature by examining mental health service use for African-American and Caucasian youth. Findings indicate differences in residential placement for youth with various problems and ethnic differences in formal referrals to care. More research is needed to compare study results over time. In addition, studies that include financial status or income are needed in order to control for these confounding factors. Research is also needed which would address the severity of presenting problems and/or test for interactions among problems in order to more precisely identify risk factors. In addition, in order to obtain a more precise understanding on the effect of referral on length of service, studies should be conducted which compute a treatment dropout rate

for youth. Intervention strategies with families and providers should be developed. Such strategies may include assessing the cultural competency of the system, incorporating the principles of cultural competency and emphasizing the strengths of extended family networks that exist in many minority communities. Furthermore, given the need and thrust for family centered services, it will be important to include a family dimension in future research studies. This is primarily because the societal reaction to the youth's deviance can also be viewed as a societal response to the family unit in many cases. These studies may indicate concerns in other segments of the social system such as schools or health agencies.

Summary

It has been stated that minority youth experience different treatment in the mental health system compared to their Caucasian counterparts. These differences include entrance into the system as well as type of services received while in the system. Few studies have examined the pathways and placements for minority youth. In order to improve service delivery to these youth it is necessary to foster a better understanding of factors that affect service use. The purpose of this study was to examine the issue of over-representation of African-American youth in restrictive residential and inpatient facilities (Snowden & Cheung, 1990; Fried, 1975; Milazzo- Sayre, Benson, Rosenstein, & Manderscheid, 1986; Virginia Department of Planning and Budget, 1990) by examining the patterns of utilization and source of referral of African-American and Caucasian youth in Virginia. The aims of this research were to provide further understanding of

minority youth's mental health utilization patterns and to describe factors that affect their referral and residential placement in mental health services through the Virginia Comprehensive Services Act.

Findings from four of the research questions could be interpreted as adding support to the labeling perspective. However, better measurements of the youth's clinical condition are needed. In addition, information related to familial attitudes regarding seeking treatment along with a provider perspective are necessary in order to more adequately test the different hypotheses relating to the labeling perspective. There is also a need to document how families, social agencies, schools and mental health entities arrange for the referral of youth to mental health care. Policy makers should be made aware of the possibility that African-Americans and Caucasians enter the system in different ways and that differential pathways may have consequences for treatment outcomes. Without additional data regarding treatment outcomes, it is difficult to interpret whether the differences are positive or negative for youth.

The findings of this study indicate some of the factors associated with referrals, out-of-home placements, residential placements and length of service in the child mental health system for youth with serious emotional and behavioral disturbances. It is recommended that this study's findings be interpreted with caution due to the inability to verify causal relationships. However, results of this study could be used as a foundation for more in-depth examination of youth's pathways to treatment. Particular attention could be given to schools and social/legal agencies and how these agencies differ in labeling the mental health

problems of youth as well as how these referrals impact the amount and type of services youth receive while in treatment.

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Appendix A

COMMONWEALTH of VIRGINIA

DEPARTMENT OF

Mental Health, Mental Retardation and Substance Abuse Services

TIMOTHY A. KELLY, Ph. D.
COMMISSIONER

P. O. BOX 1797
RICHMOND, VA 23214
(804) 786-3921
(804) 371-8977 VOICE/TDD

April 22, 1996

Vanessa Banks Sheppard
1009 Antioch Circle
Virginia Beach, VA 23464

RE: Request for use of Data

Dear Ms. Sheppard:

Thank you for your letter of April 2 requesting to use data on CSA youth for your doctoral dissertation. The client-level information we have resides on our C-SIDE data base. This software is used by approximately 35 of the 119 CPMTs in Virginia.

I spoke with the director of the CSA Office and the Director of the Research and Evaluation Office of DMHMRSAS about your request. Both agree that the data, excluding any personal identifying information, reside in the public domain. Therefore, you may have access to the data you seek. We request that you site the source of your data, that you restrict their use to your study and that you provide us a copy of your completed study.

We will try to accommodate your request with minimal impact on the workload of our MIS staff. We can provide you information from the "client" file of the data base rather easily. However, data from the "service" file will require considerably more time and effort. Please let us know which data elements you need for your study.

Best wishes for your research.

Sincerely,

Albert C. Watts, Ph.D.
CSA Evaluation Manager

ACW/s

Appendix B

COMPREHENSIVE SERVICES ACT
Youth Enrollment Information
(Minimum Data Set)

FAPT Identification #: 3000102 Youth's Name: Name 2
Date Information Entered: 1/03/94
Youth's Residence (FIPS): Youth's SSN: 222-22-2222

1. Referral Date: 11/01/93 2. CSA Enrollment Date: 11/02/93

3. Youth Date of Birth: 11/12/81 4. Gender: Female

5. Race: White Other (Specify):

6. Hispanic origin: N

7. Population Type:

8. Was the youth court-ordered to services? No

9. Date initial Individual Family Service Plan Completed: 11/14/93

10. Primary Referral Source:
Other (specify):

11. Where was youth living at time of CSA enrollment:

Other (specify):

12. Has youth officially been placed out of the home during the 12 months prior to CSA enrollment? N

If yes, indicate the number of days in the past 12 months for each type of placement:

	Placement	Days
a.	Regular Foster care	
b. X	Specialized/Therapeutic Foster Care or Therapeutic Home	2
c.	Residential Facility (12 beds or less)	
d.	Residential Facility (13 beds or more)	
e.	Detention center/Jail	
f.	Learning center	
g.	Emergency shelter(less than 30 days)	
h.	Substance Abuse facility	
i.	Psychiatric Hospital	
j.	Respite care	
k	Other:	

Other(specify):

13. Current Educational Placement of youth:
Other (explain):

14. Presenting Problems of youth:

a.		Mental retardation
b.	X	Developmental disability
c.		Substance abuse
d.		Serious emotional disturbance
e.		Autism disorder
f.		Delinquency/Court involvement
g.		Acting out behavior (e.g., runaway, curfew, incorrigible)
h.		Truancy
i.		Learning disability
j.		Poor academic performance
k.		Physically/emotionally abused
l.		Sexually abused (youth is victim)
m.		Sexually abusive (youth is perpetrator)
n.		Neglected
o.		Physical disability
p.		Visual/hearing impairment
q.		Traumatic brain injury
r.		Speech/language disorder
s.		Chronic health problem
t.		Pregnancy/Parenthood
u.		ADHD
v.		Aggressive behavior
w.		Other:

Other (specify):

Referral Source

Refer Source
Self
Family/Friend
Clergy
Judge
Attorney
Court service unit
Police/Sheriff
State hospital
State training center
Private hospital
Community Services Board
School system/Education agency/Teacher
Dept. of Social services
Dept. of Health
Homeless shelter
Formal multi-agency referral
Other

Living Arrangement

Living Arrangement
Own home/Independent living
Parent's home
Relative's home (not foster care)
Regular foster care
Specialized/Therapeutic foster care
Residential facility (12 beds or less)
Residential facility (13 beds or more)
Detention facility
Learning center
Emergency shelter (less than 30 days)
Substance abuse facility
Psychiatric hospital
Other
None (homeless, non-sheltered)

Education Placement

Education Placement
Regular classroom
Special Education
Gifted program
Special day-school
Residential school
Vocational/Technical school
Home schooling
Not currently enrolled
Homebound
Expelled-alternative education
Expelled-no alternative education
Dropped-out
Graduated from high school
Other

Service Table

Type of Service
Case Management
Early Intervention (Young Children)
Education
Employment/Vocational
Health Service
Probation Supervision
Residential--Group Care
Residential--Individual Care
Therapeutic
Other

Population Type

Population Type
Mandated Targeted
Non-mandated Targeted
Other Eligible

Appendix C

Comprehensive Services Act (1992)

CHAPTER 46.

Comprehensive Services Act for At-Risk Youth and Families.

Sec.
2.1-745. [Not set out.]
2.1-746. State executive council; members; duties.
2.1-747. State management team; appointment; membership.
2.1-748. State management team; powers and duties.
2.1-749. Duties of agencies represented on state management team.
2.1-750. (Effective July 1, 1993) Community policy and management team; appointment; fiscal agent.
2.1-751. (Effective July 1, 1993) Community policy and management teams; membership; immunity from liability.
2.1-752. (Effective July 1, 1993) Community policy and management teams; powers and duties.
2.1-753. (Effective July 1, 1993) Family assessment and planning team; membership; immunity from liability.
2.1-754. (Effective July 1, 1993) Family assessment and planning team; powers and duties.
2.1-755. (Effective July 1, 1993) Referrals to family assessment and planning teams.
2.1-756. (Effective July 1, 1993) Information sharing; confidentiality.
2.1-757. (Effective July 1, 1993) State pool of funds.
2.1-758. (Effective July 1, 1993) Eligibility for state pool of funds.
2.1-759. (Effective January 1, 1993) State trust fund.

§ 2.1-745: Not set out.

§ 2.1-746. State executive council; members; duties. — The members of the state executive council shall be the Commissioners of Health, of Mental Health, Mental Retardation and Substance Abuse Services and of Social Services; the Superintendent of Public Instruction; the Executive Secretary of the Virginia Supreme Court; the Director of the Department of Youth and Family Services; and a parent representative. The parent representative shall be appointed by the Governor for a term not to exceed three years and shall not be an employee of any public or private program which serves children and families. The council shall annually elect a chairman who shall be

responsible for convening the council. The council shall meet, at a minimum, semiannually, to oversee the administration of this chapter and make such decisions as may be necessary to carry out its purposes.

The state executive council shall:

1. Appoint the members of the state management team in accordance with the requirements of § 2.1-747;

2. Provide for the establishment of interagency programmatic and fiscal policies developed by the state management team, which support the purposes of this chapter, through the promulgation of regulations by the participating state boards or by administrative action, as appropriate;

3. Oversee the administration of state interagency policies governing the use, distribution and monitoring of moneys in the state pool of funds and the state trust fund;

4. Provide for the administration of necessary interagency functions which support the work of the state management team;

5. Review and take appropriate action on issues brought before it by the state management team; and

6. Advise the Governor and appropriate Cabinet Secretaries on proposed policy and operational changes which facilitate interagency service development and implementation, communication and cooperation. (1992, cc. 837, 880.)

§ 2.1-747. State management team; appointment; membership. — The state management team is hereby established to better serve the needs of troubled and at-risk youths and their families by managing cooperative efforts at the state level and providing support to community efforts. The team shall be appointed by and be responsible to the state executive council set out in § 2.1-746. The team shall include one representative from each of the following state agencies: the Department of Health, Department of Youth and Family Services, Department of Social Services, Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Education. The team shall also include a parent representative who is not an employee of any public or private program which serves children and families; a representative of a private organization or association of providers for children's or family services; a juvenile and domestic relations district court judge; and one member from each of five different geographical areas of the Commonwealth and who is representative of the different participants of community policy and management teams. The nonstate agency members shall serve staggered terms of not more than three years, such terms to be determined by the state executive council.

The team shall annually elect a chairman who shall be responsible for convening the team. The team shall develop and adopt bylaws to govern its operations which shall be subject to approval by the state executive council. Any person serving on such team who does not represent a public agency shall file a statement of economic interests as set out in § 2.1-639.15 of the State and Local Government Conflict of Interests Act (§ 2.1-639.1 et seq.). Persons representing public agencies shall file such statements if required to do so pursuant to the State and Local Government Conflict of Interests Act. (1992, cc. 837, 880.)

§ 2.1-748. State management team; powers and duties. — The state management team is authorized to:

1. Develop and recommend to the state executive council interagency program and fiscal policies which promote and support cooperation and collaboration in the provision of services to troubled and at-risk youths and their families at the state and local levels;

2. Develop and recommend to the state executive council state interagency policies governing the use, distribution and monitoring of moneys in the state pool of funds and the state trust fund;

3. Provide for training and technical assistance at the state level and to localities in the provision of efficient and effective services that are responsive to the strengths and needs of troubled and at-risk youths and their families; and

4. Serve as liaison to the participating state agencies which administratively support the team and which provide other necessary services by serving as fiscal agent, designing and administering the interagency tracking and evaluation system, and providing training and technical assistance. (1992, cc. 837, 880.)

§ 2.1-749. Duties of agencies represented on state management team. — The state agencies represented on the state management team shall provide administrative support for the team in the development and implementation of the collaborative system of services and funding authorized by this chapter. This support shall also include, but not be limited to, the provision of timely fiscal information, data for client- and service-tracking, and assistance in training local agency personnel on the system of services and funding established by this chapter. (1992, cc. 837, 880.)

§ 2.1-750. (Effective July 1, 1993) Community policy and management team; appointment; fiscal agent. — Every county, city, or combination of counties, cities, or counties and cities shall establish a community policy and management team in order to receive funds pursuant to this chapter. Each such team shall be appointed by the governing body of the participating local political subdivision establishing the team. In making such appointments, the governing body shall ensure that the membership is appropriately balanced among the representatives required to serve on the team in accordance with § 2.1-751. When any combination of counties, cities or counties and cities establishes a community policy and management team, the board of supervisors of each participating county or the council in the case of each participating city shall jointly establish the size of the team and the type of representatives to be selected from each locality in accordance with § 2.1-751. The governing bodies of each participating county and city served by the team shall appoint the designated representatives from their localities. The participating governing bodies shall jointly designate an official of one member city or county to act as fiscal agent for the team.

The county or city which comprises a single team and the county or city whose designated official serves as the fiscal agent for the team in the case of joint teams shall annually audit the total revenues of the team and its programs. The county or city which comprises a single team and any combination of counties or cities establishing a team shall arrange for the provision of legal services to the team. (1992, cc. 837, 880.)

Editor's note. — Acts 1992, cc. 837 and 880, cl. 5, provide that this section shall become effective July 1, 1993, "if funds are provided to carry out the purposes of this act during the 1992-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1993, specify the funding formula, including two hold harmless provisions, by which the funds are distributed to localities. The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992. The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1,

1997." Since these events have occurred, this section is effective July 1, 1993.

§ 2.1-751. (Effective July 1, 1993) Community policy and management teams; membership; immunity from liability. — The community policy and management team to be appointed by the local governing body shall include, at a minimum, the local agency heads or their designees of the following community agencies: community services board established pursuant to § 37.1-195, juvenile court services unit, department of health, department of social services and the local school division. The team shall also include a representative of a private organization or association of providers for children's or family services if such organizations or associations are located within the locality and a parent representative who is not an employee of any public or private program which serves children and families. Those persons appointed to represent community agencies shall be authorized to make policy and funding decisions for their agencies.

The local governing body may appoint other members to the team including, but not limited to, a local government official, a local law-enforcement official and representatives of other public agencies.

When any combination of counties, cities or counties and cities establishes a community policy and management team, the membership requirements previously set out shall be adhered to by the team as a whole.

Persons who serve on the team shall be immune from any civil liability for decisions made about the appropriate services for a family or the proper placement or treatment of a child who comes before the team, unless it is proven that such person acted with malicious intent. Any person serving on such team who does not represent a public agency shall file a statement of economic interests as set out in § 2.1-639.15 of the State and Local Government Conflict of Interests Act (§ 2.1-639.1 et seq.). Persons representing public agencies shall file such statements if required to do so pursuant to the State and Local Government Conflict of Interests Act. (1992, cc. 837, 880.)

Editor's note. — Acts 1992, cc. 837 and 880, cl. 5, provide that this section shall become effective July 1, 1993, "if funds are provided to carry out the purposes of this act during the 1992-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1993, specify the funding formula, including two hold harmless provisions, by which the funds are distributed to localities. The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992. The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997." Since these events have occurred, this section is effective July 1, 1993.

§ 2.1-752. (Effective July 1, 1993) Community policy and management teams; powers and duties. — The community policy and management team shall manage the cooperative effort in each community to better serve the needs of troubled and at-risk youths and their families and to maximize the use of state and community resources. Every such team shall:

1. Develop interagency policies and procedures to govern the provision of services to children and families in its community;

2. Develop interagency fiscal policies governing access to the state pool of funds by the eligible populations including immediate access to funds for emergency services and shelter care;

3. Coordinate long-range, community-wide planning which ensures the development of resources and services needed by children and families in its community;

4. Establish policies governing referrals and reviews of children and families to the family assessment and planning teams and a process to review the teams' recommendations and requests for funding;

5. Establish quality assurance and accountability procedures for program utilization and funds management;

6. Establish procedures for obtaining bids on the development of new services;

7. Manage funds in the interagency budget allocated to the community from the state pool of funds, the trust fund, and any other source;

8. Authorize and monitor the expenditure of funds by each family assessment and planning team;

9. Have authority to submit grant proposals which benefit its community to the state trust fund and to enter into contracts for the provision or operation of services upon approval of the participating governing bodies; and

10. Serve as its community's liaison to the state management team, reporting on its programmatic and fiscal operations and on its recommendations for improving the service system, including consideration of realignment of geographical boundaries for providing human services. (1992, cc. 837, 880.)

Editor's note. — Acts 1992, cc. 837 and 880, cl. 5, provide that this section shall become effective July 1, 1993, "if funds are provided to carry out the purposes of this act during the 1992-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1993, specify the funding formula, including two hold harmless provisions, by which the funds are distributed to localities. The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992. The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997." Since these events have occurred, this section is effective July 1, 1993.

§ 2.1-753. (Effective July 1, 1993) Family assessment and planning team; membership; immunity from liability. — Each community policy and management team shall establish and appoint one or more family assessment and planning teams as the needs of the community require. Each family assessment and planning team shall include representatives of the following community agencies who have authority to access services within their respective agencies: community services board established pursuant to § 37.1-195, juvenile court services unit, department of health, department of social services, local school division and a parent representative who is not an employee of any public or private program which serves children and families. The family assessment and planning team may include a representative of a private organization or association of providers for children's or family services and of other public agencies.

Persons who serve on a family assessment and planning team shall be immune from any civil liability for decisions made about the appropriate services for a family or the proper placement or treatment of a child who comes before the team, unless it is proven that such person acted with malicious intent. Any person serving on such team who does not represent a public agency shall file a statement of economic interests as set out in § 2.1-639.15 of the State and Local Government Conflict of Interests Act (§ 2.1-639.1 et seq.). Persons representing public agencies shall file such

statements if required to do so pursuant to the State and Local Government Conflict of Interests Act. (1992, cc. 837, 880.)

Editor's note. — Acts 1992, cc. 837 and 880, cl. 5, provide that this section shall become effective July 1, 1993. "If funds are provided to carry out the purposes of this act during the 1992-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1993, specify the funding formula, including two hold harmless provisions, by which the funds are distributed to localities. The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992. The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997." Since these events have occurred, this section is effective July 1, 1993.

§ 2.1-754. (Effective July 1, 1993) Family assessment and planning team; powers and duties. — The family assessment and planning team shall assess the strengths and needs of troubled youths and families who are approved for referral to the team and identify and determine the complement of services required to meet these unique needs.

Every such team, in accordance with policies developed by the community policy and management team, shall:

1. Review referrals of youths and families to the team;
2. Provide for family participation in all aspects of assessment, planning and implementation of services;
3. Develop an individual family services plan for youths and families reviewed by the team which provides for appropriate and cost-effective services;
4. Refer the youth and family to community agencies and resources in accordance with the individual family services plan;
5. Recommend to the community policy and management team expenditures from the local allocation of the state pool of funds; and
6. Designate a person who is responsible for monitoring and reporting, as appropriate, on the progress being made in fulfilling the individual family services plan developed for each youth and family, such reports to be made to the team or the responsible local agencies. (1992, cc. 837, 880.)

Editor's note. — Acts 1992, cc. 837 and 880, cl. 5, provide that this section shall become effective July 1, 1993. "If funds are provided to carry out the purposes of this act during the 1992-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1993, specify the funding formula, including two hold harmless provisions, by which the funds are distributed to localities. The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992. The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997." Since these events have occurred, this section is effective July 1, 1993.

§ 2.1-755. (Effective July 1, 1993) Referrals to family assessment and planning teams. — The community policy and management team shall establish policies governing the referral of troubled youths and families to the family assessment and planning team. These policies shall include which youths and families are to be assessed by the family assessment and planning team and shall consider the criteria set out in § 2.1-758 A 1 and 2.

The community policy and management team shall also establish policies governing the circumstances under which youths and families are not required to be assessed by a family assessment and planning team, but for whom funds from the state pool may be directly accessed to pay for specified services. (1992, cc. 837, 880.)

Editor's note. — Acts 1992, cc. 837 and 880, cl. 5, provide that this section shall become effective July 1, 1993, "if funds are provided to carry out the purposes of this act during the 1992-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1993, specify the funding formula, including two hold harmless provisions, by which the funds are distributed to localities. The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992. The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997." Since these events have occurred, this section is effective July 1, 1993.

§ 2.1-756. (Effective July 1, 1993) Information sharing; confidentiality. — All public agencies which have served a family or treated a child referred to a family assessment and planning team shall cooperate with this team. The agency which refers a youth and family to the team shall be responsible for obtaining the consent required to share agency client information with the team. After obtaining the proper consent, all agencies shall promptly deliver, upon request and without charge, such records of services, treatment or education of the family or child as are necessary for a full and informed assessment by the team.

Proceedings held to consider the appropriate provision of services and funding for a particular child or family or both who have been referred to the family assessment and planning team and whose case is being assessed by this team or reviewed by the community management and planning team shall be confidential and not open to the public, unless the child and family who are the subjects of the proceeding request, in writing, that it be open. All information about specific children and families obtained by the team members in the discharge of their responsibilities to the team shall be confidential.

Demographic, service and cost information on youths and families receiving services and funding through this chapter which is of a nonidentifying nature may be gathered for reporting and evaluation purposes. (1992, cc. 837, 880.)

Editor's note. — Acts 1992, cc. 837 and 880, cl. 5, provide that this section shall become effective July 1, 1993, "if funds are provided to carry out the purposes of this act during the 1992-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1993, specify the funding formula, including two hold harmless provisions, by which the funds are distributed to localities. The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992. The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997." Since these events have occurred, this section is effective July 1, 1993.

§ 2.1-757. (Effective July 1, 1993) State pool of funds. — A. Effective July 1, 1993, there is established a state pool of funds to be allocated to community policy and management teams in accordance with the appropriations act and appropriate state regulations. These funds, as made available by the General Assembly, shall be expended for public or private nonresidential or residential services for troubled youths and families.

The purposes of this system of funding are:

1. To place authority for making program and funding decisions at the community level;

2. To consolidate categorical agency funding and institute community responsibility for the provision of services;

3. To provide greater flexibility in the use of funds to purchase services based on the strengths and needs of youths and families; and

4. To reduce disparity in accessing services and to reduce inadvertent fiscal incentives for serving children according to differing required local match rates for funding streams.

B. The state pool shall consist of funds which serve the target populations identified in subdivisions 1 through 5 below in the purchase of residential and nonresidential services for children. References to funding sources and current placement authority for the targeted populations of children are for the purpose of accounting for the funds in the pool. It is not intended that children be categorized by individual funding streams in order to access services. The target population shall be the following:

1. Children placed for purposes of special education in approved private school educational programs, previously funded by the Department of Education through private tuition assistance;

2. Handicapped children placed by local social services agencies or the Department of Youth and Family Services in private residential facilities or across jurisdictional lines in private, special education day schools, if the individualized education program indicates such school is the appropriate placement while living in foster homes or child-caring facilities, previously funded by the Department of Education through the Interagency Assistance Fund for Noneducational Placements of Handicapped Children;

3. Children for whom foster care services, as defined by § 63.1-55.8, are being provided to prevent foster care placements, and children entrusted to local social service agencies by their parents or guardians or committed to the agencies by any court of competent jurisdiction for purposes of placement in suitable family homes, child-caring institutions, residential facilities or independent living arrangements, as authorized by § 63.1-56;

4. Children placed by a juvenile and domestic relations district court, in accordance with the provisions of § 16.1-286, in a private or locally operated public facility or nonresidential program; and

5. Children committed to the Department of Youth and Family Services and placed by it in a private home or in a public or private facility in accordance with § 66-14.

C. The General Assembly and the governing body of each county and city shall annually appropriate such sums of money as shall be sufficient (i) to provide special education services and foster care services for children identified in subdivisions B 1, B 2 and B 3 of this section and (ii) to meet relevant federal mandates for the provision of these services. The community policy and management team shall anticipate to the best of its ability the number of children for whom such services will be required and reserve funds from its state pool allocation to meet these needs.

D. When a community services board established pursuant to § 37.1-195, local school division, local social service agency, court service unit, or the Department of Youth and Family Services has referred a child and family to a

family assessment and planning team and that team has recommended the proper level of treatment and services needed by that child and family and has determined the child's eligibility for funding for services through the state pool of funds, then the community services board, the local school division, local social services agency, court service unit or Department of Youth and Family Services has met its fiscal responsibility for that child for the services funded through the pool. Each agency shall continue to be responsible for providing services identified in individual family service plans which are within the agency's scope of responsibility and which are funded separately from the state pool. (1992, cc. 837, 880.)

Editor's note. — Acts 1992, cc. 837 and 880, cl. 5, provide that this section shall become effective July 1, 1993, "if funds are provided to carry out the purposes of this act during the 1992-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1993, specify the funding formula, including two hold harmless provisions, by which the funds are distributed to localities. The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992. The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997." Since these events have occurred, this section is effective July 1, 1993.

§ 2.1-758. (Effective July 1, 1993) Eligibility for state pool of funds. — A. In order to be eligible for funding for services through the state pool of funds, a youth, or family with a child, shall meet one or more of the criteria specified in subdivisions 1 through 4 below and shall be determined by policies of the community policy and management team to have access to these funds.

1. The child or youth has emotional or behavior problems which:

a. Have persisted over a significant period of time or, though only in evidence for a short period of time, are of such a critical nature that intervention is warranted;

b. Are significantly disabling and are present in several community settings, such as at home, in school or with peers; and

c. Require services or resources that are unavailable or inaccessible, or that are beyond the normal agency services or routine collaborative processes across agencies, or require coordinated interventions by at least two agencies.

2. The child or youth has emotional or behavior problems, or both, and currently is in, or is at imminent risk of entering, purchased residential care. In addition, the child or youth requires services or resources that are beyond normal agency services or routine collaborative processes across agencies, and requires coordinated services by at least two agencies.

3. The child or youth requires placement for purposes of special education in approved private school educational programs.

4. The child or youth has been entrusted to a local social services agency by his parents or guardian or has been committed to the agency by a court of competent jurisdiction for the purposes of placement as authorized by § 63.1-56.

B. For purposes of determining eligibility for the state pool of funds, "child" or "youth" means (i) a person less than eighteen years of age and (ii) any individual through twenty-one years of age who is otherwise eligible for mandated services of the participating state agencies including special education and foster care services. (1992, cc. 837, 880.)

Editor's note. — Acts 1992, cc. 837 and 880, cl. 5, provide that this section shall become effective July 1, 1993, "if funds are provided to carry out the purposes of this act during the 1992-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1993, specify the funding formula, including two hold harmless provisions, by which the funds are distributed to localities. The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992. The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997." Since these events have occurred, this section is effective July 1, 1993.

§ 2.1-759. (Effective January 1, 1993) State trust fund. — A. Effective January 1, 1993, there is established a state trust fund with funds appropriated by the General Assembly. The purposes of this fund are to develop:

1. Early intervention services for young children at risk of developing emotional or behavior problems, or both, due to environmental, physical or psychological stress, and their families; and

2. Community services for troubled youths who have emotional or behavior problems, or both, and who can appropriately and effectively be served in the home or community, or both, and their families.

The fund shall consist of moneys from the state general fund, federal grants, and private foundations.

B. Proposals for requesting these funds shall be made by community policy and management teams to the state management team. The state management team shall make recommendations on the proposals it receives to the state executive council, which shall award the grants to the community teams in accordance with the policies developed under the authority of § 2.1-748 of this chapter. (1992, cc. 837, 880.)

Editor's note. — Acts 1992, cc. 837 and 880, cl. 3, provide: "That § 2.1-759 shall become effective January 1, 1993, if state funds are provided to carry out the purposes of this section during the 1992 Session of the General Assembly." Since this event has occurred, this section is effective July 1, 1993.

An Act to amend and reenact the fourth and fifth enactments of Chapter 837 of the Acts of Assembly of 1992; to amend and reenact the fourth and fifth enactments of Chapter 880 of the Acts of Assembly of 1992; and to amend and reenact Chapter 837 and Chapter 880 of the Acts of Assembly of 1992 by adding a sixth enactment, providing for a funding formula for the Comprehensive Services Act for At-Risk Youth and Families.

[S 783]

Approved [redacted] 17 [redacted]

Be it enacted by the General Assembly of Virginia:

1. That the fourth and fifth enactments of Chapter 837 of the Acts of Assembly of 1992 are amended and reenacted and that such chapter is further amended by adding a sixth enactment as follows:

4. That §§ ~~2.1-700,~~ 2.1-701 and 2.1-702 of the Code of Virginia are repealed effective July 1, 1993 ~~; if funds are provided to carry out the purposes of this act during the 1992-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1992, specify the funding formula, including two hold harmless provisions as described below, by which the funds are distributed to localities~~ .

~~The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992.~~

~~The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997.~~

5. That §§ 2.1-750 through 2.1-758 *of the Code of Virginia* and the amendments to §§ 2.1-1.7, 9-6.25:1, 16.1-278.5, 16.1-286, 16.1-294, 22.1-101.1, 37.1-197.1, 63.1-55, 63.1-248.6, 66-14 and 66-35 *of the Code of Virginia* shall become effective July 1, 1993 ~~; if funds are provided to carry out the purposes of this act during the 1992-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1992, specify the funding formula, including two hold harmless provisions, by which the funds are distributed to localities~~ .

~~The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992.~~

~~The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997.~~

6. That the funding formula to carry out the purposes of this act is as follows:

1. Base year funds for localities.—No locality shall ever receive less state funds in accordance with § 2.1-757 of the Code of Virginia than it received in the base year which is defined as Fiscal Year 1992. The match for a locality to draw this base year allocation of state funds shall be the same dollar amount as the locality paid in Fiscal Year 1992 to match state funds.

2. Formula for state funds.—The following formula shall be used to compute a locality's allocation of state dollars in excess of the amount it received in the base year which is defined as Fiscal Year 1992: total youth population age 0-17 years as reported in the United States Census (33.33 percent); food stamp recipients in households with a child under the age of eighteen as reported by the Department of Social Services (33.33 percent); founded and reason to suspect child protective services complaints as reported by the Department of Social Services (17.75 percent); seriously emotionally disturbed or learning disabled children as reported by the Department of Education (10.34 percent); and juvenile court intake complaints as reported by the Department of Youth and Family Services (5.25 percent).

The data used to compute this formula shall be updated annually based on the latest available information.

Every locality shall receive the larger of $25,000 or an amount determined by computing a locality's formula allocation. The amount to be allocated by formula is

defined as appropriations in excess of Fiscal Year 1992 expenditures.

3. Allocation adjustment.—Any locality whose total allocation for Fiscal Year 1994 through the state pool of funds, established by § 2.1-757, is less than the expenditures it incurred in Fiscal Year 1993 to meet the same service needs for youth and families, shall have its Fiscal Year 1994 allocation increased by the State Executive Council, established by § 2.1-746, if the Council determines the locality's expenditures for Fiscal Year 1993 reflect a more accurate level of expenditures over time. Any such adjustments shall be made by October 1, 1993.

4. Local match.—A locality's match for all state funds that exceed the amount it received in Fiscal Year 1992 shall be computed by using each locality's per capita revenue capacity as determined by the Commission on Local Government divided by the statewide per capita revenue capacity. The resulting ratio for each locality shall be multiplied by an aggregate local share of forty-five percent. Each local share shall then be adjusted according to income in each locality, as determined by dividing the median adjusted gross income for all state income tax returns in each locality by the median adjusted gross income for all income tax returns statewide. Local shares shall not exceed forty-five percent of the total new funds allocated by the formula established by this act.

The data used to compute local match rates shall use the most recent information published by the Commission on Local Governments and shall be updated once each biennium.

5. Definition.—For the purposes of the sixth enactment clause, "locality" means any county or city.

2. That the fourth and fifth enactments of Chapter 880 of the Acts of Assembly of 1992 are amended and reenacted and that such chapter is further amended by adding a sixth enactment as follows:

4. That §§ ~~2.1-700,~~ 2.1-701 and 2.1-702 of the Code of Virginia are repealed effective July 1, 1993 ~~, if funds are provided to carry out the purposes of this act during the 1993-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1993, specify the funding formula, including two hold harmless provisions as described below, by which the funds are distributed to localities~~ .

~~The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992.~~

~~The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997.~~

5. That §§ 2.1-750 through 2.1-758 *of the Code of Virginia* and the amendments to §§ 2.1-1.7, 9-6.25:1, 16.1-278.5, 16.1-286, 16.1-294, 22.1-101.1, 37.1-197.1, 63.1-55, 63.1-248.6, 66-14 and 66-35 *of the Code of Virginia* shall become effective July 1, 1993 ~~, if funds are provided to carry out the purposes of this act during the 1993-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1993, specify the funding formula, including two hold harmless provisions, by which the funds are distributed to localities~~ .

~~The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992.~~

~~The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997.~~

6. That the funding formula to carry out the purposes of this act is as follows:

1. Base year funds for localities.—No locality shall ever receive less state funds in accordance with § 2.1-757 of the Code of Virginia than it received in the base year which is defined as Fiscal Year 1992. The match for a locality to draw this base year allocation of state funds shall be the same dollar amount as the locality paid in Fiscal Year 1992 to match state funds.

2. Formula for state funds.—The following formula shall be used to compute a locality's allocation of state dollars in excess of the amount it received in the base year which is defined as Fiscal Year 1992: total youth population age 0-17 years as reported in the United States Census (33.33 percent); food stamp recipients in households with a child under the age of eighteen as reported by the Department of Social Services (33.33 percent); founded and reason to suspect child protective services complaints as reported by

the Department of Social Services (17.73 percent); seriously emotionally disturbed or learning disabled children as reported by the Department of Education (10.34 percent); and juvenile court intake complaints as reported by the Department of Youth and Family Services (5.35 percent).

The data used to compute this formula shall be updated annually based on the latest available information.

Every locality shall receive the larger of $25,000 or an amount determined by computing a locality's formula allocation. The amount to be allocated by formula is defined as appropriations in excess of Fiscal Year 1992 expenditures.

3. Allocation adjustment.—Any locality whose total allocation for Fiscal Year 1994 through the state pool of funds, established by § 2.1-757, is less than the expenditures it incurred in Fiscal Year 1993 to meet the same service needs for youth and families, shall have its Fiscal Year 1994 allocation increased by the State Executive Council, established by § 2.1-746, if the Council determines the locality's expenditures for Fiscal Year 1993 reflect a more accurate level of expenditures over time. Any such adjustments shall be made by October 1, 1993.

4. Local match.—A locality's match for all state funds that exceed the amount it received in Fiscal Year 1992 shall be computed by using each locality's per capita revenue capacity as determined by the Commission on Local Government divided by the statewide per capita revenue capacity. The resulting ratio for each locality shall be multiplied by an aggregate local share of forty-five percent. Each local share shall then be adjusted according to income in each locality, as determined by dividing the median adjusted gross income for all state income tax returns in each locality by the median adjusted gross income for all income tax returns statewide. Local shares shall not exceed forty-five percent of the total new funds allocated by the formula established by this act.

The data used to compute local match rates shall use the most recent information published by the Commission on Local Governments and shall be updated once each biennium.

5. Definition.—For purposes of the sixth enactment clause, "locality" means any county or city.

President of the Senate

Speaker of the House of Delegates

Approved:

Governor

SB 783 and HB 1748

Funding Formula Amendment

to

The Comprehensive Services Act

An Act to amend and reenact the fourth and fifth enactments of Chapter 837 of the Acts of Assembly of 1992; to amend and reenact the fourth and fifth enactments of Chapter 880 of the Acts of Assembly of 1992; and to amend and reenact Chapter 837 and Chapter 880 of the Acts of Assembly of 1992 by adding a sixth enactment, providing for a funding formula for the Comprehensive Services Act for At-Risk Youth and Families.

[H 1748]

Approved MAR 15 1993

Be it enacted by the General Assembly of Virginia:

1. That the fourth and fifth enactments of Chapter 837 of the Acts of Assembly of 1992 are amended and reenacted and that such chapter is further amended by adding a sixth enactment as follows:

4. That §§ ~~2.1-700,~~ 2.1-701 and 2.1-702 of the Code of Virginia are repealed effective July 1, 1993 ~~if funds are provided to carry out the purposes of this act during the 1992-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1993 specify the funding formula, including two hold harmless provisions as described below, by which the funds are distributed to localities~~.

~~The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992.~~

~~The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997.~~

5. That §§ 2.1-750 through 2.1-758 *of the Code of Virginia* and the amendments to §§ 2.1-1.7, 9-6.25:1, 16.1-278.5, 16.1-286, 16.1-294, 22.1-101.1, 37.1-197.1, 63.1-55, 63.1-248.6, 66-14 and 66-35 *of the Code of Virginia* shall become effective July 1, 1993 ~~if funds are provided to carry out the purposes of this act during the 1992-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1993 specify the funding formula, including two hold harmless provisions, by which the funds are distributed to localities~~.

~~The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992.~~

~~The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997.~~

6. That the funding formula to carry out the purposes of this act is as follows:

1. Base year funds for localities.—No locality shall ever receive less state funds in accordance with § 2.1-757 of the Code of Virginia than it received in the base year which is defined as Fiscal Year 1992. The match for a locality to draw this base year allocation of state funds shall be the same dollar amount as the locality paid in Fiscal Year 1992 to match state funds.

2. Formula for state funds.—The following formula shall be used to compute a locality's allocation of state dollars in excess of the amount it received in the base year which is defined as Fiscal Year 1992: total youth population age 0-17 years as reported in the United States Census (33.33 percent); food stamp recipients in households with a child under the age of eighteen as reported by the Department of Social Services (33.33 percent); founded and reason to suspect child protective services complaints as reported by the Department of Social Services (17.75 percent); seriously emotionally disturbed or learning disabled children as reported by the Department of Education (10.34 percent), and juvenile court intake complaints as reported by the Department of Youth and Family Services (5.25 percent).

The data used to compute this formula shall be updated annually based on the latest available information.

Every locality shall receive the larger of $25,000 or an amount determined by computing a locality's formula allocation. The amount to be allocated by formula is

defined as appropriations in excess of Fiscal Year 1992 expenditures.

3. Allocation adjustment.—Any locality whose total allocation for Fiscal Year 1994 through the state pool of funds, established by § 2.1-757, is less than the expenditures it incurred in Fiscal Year 1993 to meet the same service needs for youth and families, shall have its Fiscal Year 1994 allocation increased by the State Executive Council, established by § 2.1-746, if the Council determines the locality's expenditures for Fiscal Year 1993 reflect a more accurate level of expenditures over time. Any such adjustments shall be made by October 1, 1993.

4. Local match.—A locality's match for all state funds that exceed the amount it received in Fiscal Year 1992 shall be computed by using each locality's per capita revenue capacity as determined by the Commission on Local Government divided by the statewide per capita revenue capacity. The resulting ratio for each locality shall be multiplied by an aggregate local share of forty-five percent. Each local share shall then be adjusted according to income in each locality, as determined by dividing the median adjusted gross income for all state income tax returns in each locality by the median adjusted gross income for all income tax returns statewide. Local shares shall not exceed forty-five percent of the total new funds allocated by the formula established by this act.

The data used to compute local match rates shall use the most recent information published by the Commission on Local Government and shall be updated once each biennium.

5. Definition.—For the purposes of this sixth enactment clause, "locality" means any county or city.

2. That the fourth and fifth enactments of Chapter 880 of the Acts of Assembly of 1992 are amended and reenacted and that such chapter is further amended by adding a sixth enactment as follows:

4. That §§ ~~2.1-700,~~ 2.1-701 and 2.1-702 of the Code of Virginia are repealed effective July 1, 1993 ~~if funds are provided to carry out the purposes of this act during the 1992-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1993 specify the funding formula, including two hold harmless provisions as described below, by which the funds are distributed to localities~~ .

~~The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992.~~

~~The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997.~~

5. That §§ 2.1-750 through 2.1-758 *of the Code of Virginia* and the amendments to §§ 2.1-1.7, 9-6.25:1, 16.1-278.5, 16.1-286, 16.1-294, 22.1-101.1, 37.1-197.1, 63.1-55, 63.1-248.6, 66-14 and 66-35 *of the Code of Virginia* shall become effective July 1, 1993 ~~if funds are provided to carry out the purposes of this act during the 1992-94 biennium and the appropriation act and legislation amending the Code of Virginia effective on July 1, 1993 specify the funding formula, including two hold harmless provisions, by which the funds are distributed to localities~~ .

~~The state hold harmless provision shall provide that no locality ever receive less state funds than it received in the base year which is fiscal year 1992.~~

~~The local hold harmless provision shall provide that the match for a locality shall be no more than the amount it would have paid for its allocation in the base year which is fiscal year 1992. The local provision shall not hold harmless a locality's cost of matching state dollars in excess of the amount received in the base year. The local provision shall be phased out during the next two bienniums and eliminated effective July 1, 1997.~~

6. That the funding formula to carry out the purposes of this act is as follows:

1. Base year funds for localities.—No locality shall ever receive less state funds in accordance with § 2.1-757 of the Code of Virginia than it received in the base year which is defined as Fiscal Year 1992. The match for a locality to draw this base year allocation of state funds shall be the same dollar amount as the locality paid in Fiscal Year 1992 to match state funds.

2. Formula for state funds.—The following formula shall be used to compute a locality's allocation of state dollars in excess of the amount it received in the base year which is defined as Fiscal Year 1992: total youth population age 0-17 years as reported in the United States Census (33.33 percent); food stamp recipients in households with a child under the age of eighteen as reported by the Department of Social Services (33.33 percent), founded and reason to suspect child protective services complaints as reported by

the Department of Social Services (17.75 percent); seriously emotionally disturbed or learning disabled children as reported by the Department of Education (10.34 percent), and juvenile court intake complaints as reported by the Department of Youth and Family Services (5.25 percent).

The data used to compute this formula shall be updated annually based on the latest available information.

Every locality shall receive the larger of $25,000 or an amount determined by computing a locality's formula allocation. The amount to be allocated by formula is defined as appropriations in excess of Fiscal Year 1992 expenditures.

3. Allocation adjustment.—Any locality whose total allocation for Fiscal Year 1994 through the state pool of funds, established by § 2.1-757, is less than the expenditures it incurred in Fiscal Year 1993 to meet the same service needs for youth and families, shall have its Fiscal Year 1994 allocation increased by the State Executive Council, established by § 2.1-746, if the Council determines the locality's expenditures for Fiscal Year 1993 reflect a more accurate level of expenditures over time. Any such adjustments shall be made by October 1, 1993.

4. Local match.—A locality's match for all state funds that exceed the amount it received in Fiscal Year 1992 shall be computed by using each locality's per capita revenue capacity as determined by the Commission on Local Government divided by the statewide per capita revenue capacity. The resulting ratio for each locality shall be multiplied by an aggregate local share of forty-five percent. Each local share shall then be adjusted according to income in each locality, as determined by dividing the median adjusted gross income for all state income tax returns in each locality by the median adjusted gross income for all income tax returns statewide. Local shares shall not exceed forty-five percent of the total new funds allocated by the formula established by this act.

The data used to compute local match rates shall use the most recent information published by the Commission on Local Government and shall be updated once each biennium.

5. Definition.—For the purposes of this sixth enactment clause, "locality" means any county or city.

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President of the Senate

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Speaker of the House of Delegates

Approved:

_____

Governor

A-3

SB 671

The IFSP and the Court

Amendment

to

The Comprehensive Services Act

AP-20

An Act to amend and reenact § 2.1-757 of the Code of Virginia, relating to the state pool of funds for at-risk youth and families.

[S 671]

Approved MAR 2 5 1993

Be it enacted by the General Assembly of Virginia:

1. That § 2.1-757 of the Code of Virginia is amended and reenacted as follows:

§ 2.1-757. (Effective July 1, 1993) State pool of funds.—A. Effective July 1, 1993, there is established a state pool of funds to be allocated to community policy and management teams in accordance with the appropriations act and appropriate state regulations. These funds, as made available by the General Assembly, shall be expended for public or private nonresidential or residential services for troubled youths and families.

The purposes of this system of funding are:

1. To place authority for making program and funding decisions at the community level;

2. To consolidate categorical agency funding and institute community responsibility for the provision of services;

3. To provide greater flexibility in the use of funds to purchase services based on the strengths and needs of youths and families; and

4. To reduce disparity in accessing services and to reduce inadvertent fiscal incentives for serving children according to differing required local match rates for funding streams.

B. The state pool shall consist of funds which serve the target populations identified in subdivisions 1 through 5 below in the purchase of residential and nonresidential services for children. References to funding sources and current placement authority for the targeted populations of children are for the purpose of accounting for the funds in the pool. It is not intended that children be categorized by individual funding streams in order to access services. The target population shall be the following:

1. Children placed for purposes of special education in approved private school educational programs, previously funded by the Department of Education through private tuition assistance;

2. Handicapped children placed by local social services agencies or the Department of Youth and Family Services in private residential facilities or across jurisdictional lines in private, special education day schools, if the individualized education program indicates such school is the appropriate placement while living in foster homes or child-caring facilities, previously funded by the Department of Education through the Interagency Assistance Fund for Noneducational Placements of Handicapped Children;

3. Children for whom foster care services, as defined by § 63.1-55.8, are being provided to prevent foster care placements, and children entrusted to local social service agencies by their parents or guardians or committed to the agencies by any court of competent jurisdiction for purposes of placement in suitable family homes, child-caring institutions, residential facilities or independent living arrangements, as authorized by § 63.1-56;

4. Children placed by a juvenile and domestic relations district court, in accordance with the provisions of § 16.1-286, in a private or locally operated public facility or nonresidential program; and

5. Children committed to the Department of Youth and Family Services and placed by it in a private home or in a public or private facility in accordance with § 66-14.

C. The General Assembly and the governing body of each county and city shall annually appropriate such sums of money as shall be sufficient (i) to provide special education services and foster care services for children identified in subdivisions B 1, B 2 and B 3 of this section and (ii) to meet relevant federal mandates for the provision of these services. The community policy and management team shall anticipate to the best of its ability the number of children for whom such services will be required and reserve funds from its state pool allocation to meet these needs.

D. When a community services board established pursuant to § 37.1-195, local school division, local social service agency, court service unit, or the Department of Youth and Family Services has referred a child and family to a family assessment and planning team and that team has recommended the proper level of treatment and services needed by that child and family and has determined the child's eligibility for funding for services through the state pool of funds, then the community services board, the local school division, local social services agency, court service unit or Department of Youth and Family Services has

met its fiscal responsibility for that child for the services funded through the pool. Each agency shall continue to be responsible for providing services identified in individual family service plans which are within the agency's scope of responsibility and which are funded separately from the state pool.

E. In any matter properly before a court wherein the family assessment and planning team has recommended a level of treatment and services needed by the child and family, the court shall consider the recommendations of the family assessment and planning team. However, the court may make such other disposition as is authorized or required by law, and services ordered pursuant to such disposition shall qualify for funding under this section.

President of the Senate

Speaker of the House of Delegates

Approved:

Governor

VITA

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Her published abstracts include:

Sheppard, V. (1995). Rural and urban comparison of child mental health services barriers. *Proceedings of the 123rd Meeting of the American Public Health Association.*

Sheppard, V. & Benjamin-Coleman, R. (1994). Alcohol, drug use and related risk behaviors in an urban adolescent population. *Proceedings of the 122nd Annual Meeting of the American Public Health Association.*

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